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1989 REPORT OF THE PHYSICIAN PAYMENT REVIEW COMMISSION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MARCH 21, 1989

Serial 101-40

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1989 REPORT OF THE PHYSICIAN PAYMENT REVIEW COMMISSION

TUESDAY, MARCH 21, 1989

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:09 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
MONDAY, MARCH 13, 1989

PRESS RELEASE #6
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE 1989 REPORT OF THE PHYSICIAN PAYMENT REVIEW COMMISSION

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee will hold a hearing on the 1989 report of the Physician Payment Review Commission. The hearing will be held on Tuesday, March 21, 1989, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said: "Medicare's system for paying for physicians' services is badly out of date. Costs to the elderly and the taxpayers are increasing by an average rate in excess of 15 percent a year. We can no longer afford to delay corrective legislation. I look forward to recommendations from the Physician Payment Review Commission to assist Congress with this difficult task".

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND

Medicare pays for physicians' services on a fee-for-service basis. The Medicare-approved charge for a service is set at the lowest of the physician's actual or customary charge, or the prevailing charge in the locality. This mechanism has changed little since the enactment of Medicare in 1965.

Recently, there has been increasing awareness of the need for fundamental reform of physician payment under Medicare. Major concerns focus around three issues: rapid increases in program costs, high out-of-pocket costs for the elderly, and significant inequities in payment allowances.

To assist in developing a strategy for payment reform, Congress established the Physician Payment Review Commission in 1986. In its 1987 and 1988 reports to Congress, the Commission has established a general framework for change.

The Commission will formally submit its third annual report to Congress at the end of April. This report is expected to contain a number of specific recommendations for consideration by the Congress.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, April 7, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the office of the Subcommittee on Health, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman **Stark**. The Subcommittee on Health of the Committee on Ways and Means will begin today's hearing which will focus on the 1989 report to Congress of the Physician Payment Review Commission, PhysPRC. The Commission once again has done an outstanding job.

This is the first of a series of hearings on budget reconciliation issues related to physician reimbursement.

We first focused on this issue in 1983 when the concern over mounting costs grew. Unfortunately, Medicare's payment system has remained unchanged, and program costs have continued to escalate very rapidly.

Total outlays for physician services have more than doubled over the past 5 years, increasing at a compounded rate of almost 16 percent a year, from $13 billion in 1983 to $28 billion in 1988.

We cannot afford to put off decisions on how to reverse this alarming growth rate any longer. Fortunately, the Commission's report provides thoughtful guidance for Congress. So we can make necessary changes if we have the political will to do so.

Any payment reform package must address three main issues.

First, and foremost, Medicare beneficiaries must have protection from the escalating personal costs of medical bills. We have made considerable progress in this area, and the participating physician program has been an unqualified success. As a result, physicians now accept assignment on almost 80 percent of the services they provide.

But more remains to be done. Extra billing still costs beneficiaries more than $3.5 billion a year. Over a million beneficiaries will incur extra billing liabilities in excess of $1,000 this year, and that is money not covered by Medicare or not covered by the catastrophic bill.

Second, any payment reform package must control the total costs. These costs that we have talked about have been doubling every 5 years. More than half of this cost increase is due to increases in volume. That means that payment reform must address the volume issue as well.

We cannot continue to pass these cost increases on to the elderly for their 25 percent or to the taxpayers at large for the approximately 75 percent they are paying. Costs can be controlled without risk to quality.

The fundamental problem is that Medicare gives doctors a blank check. The more services they provide, the more they earn whether or not the services are really needed. Payment reform must correct this perverse incentive.

Finally, payment reform should address the issue of equity.

The Harvard resource based relative value scale study strongly suggests that Medicare overcompensates for technical services, such as diagnostic tests and surgery, and undercompensates primary care services, such as office and nursing home visits.

Geographic inequities in payment have also been identified.

The subcommittee has previously focused on overpriced procedures as a way of achieving budget savings in an equitable manner. The administration has made similar proposals for the fiscal year 1990 budget.

The Commission's report addresses each of these three major areas of concern. The Commission has made significant recommendations to reduce extra billing for beneficiaries, to control total program costs to the taxpayers, and to improve equity in payments for physicians. I expect the subcommittee will give careful consideration to the Commission's recommendations as a package.

Mr. Chandler.

Mr. CHANDLER. No.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. No.

Chairman STARK. Mr. Levin.

Mr. LEVIN. No.

Chairman STARK. I would now like to call Dr. Philip R. Lee, the Chairman of the Physician Payment Review Commission, as our first witness. He will be accompanied by the Commission's Executive Director, Mr. Paul Ginsburg.

We are pleased to have you gentlemen back with the committee once again. Please proceed to enlighten us in any manner you would care to.

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL GINSBURG, EXECUTIVE DIRECTOR

Dr. LEE. Thank you very much, Mr. Chairman. We do have a statement which we would like to submit for the record.

Chairman STARK. Without objection, Dr. Lee, your statement and the prepared statements of all of the witnesses today will appear in their entirety in the record. For any subsequent answers, the record will stay open for any letters or subsequent information you care to submit.

Dr. LEE. Thank you.

The Physician Payment Review Commission has developed proposals to rationalize the patterns of payments to physicians by Medicare and to slow the rate of increase in program costs so that they are affordable to beneficiaries and taxpayers. It met on March 9 and 10 and approved the recommendations to be included in its 1989 report to Congress, which will be submitted by April 30.

To rationalize the pattern of payments by Medicare, the Commission proposed a Medicare fee schedule based primarily on resource costs. To limit beneficiary financial liability, it recommends limits on balance billing. To control growth in expenditures, the Commission proposes the use of expenditure targets and increased research on effectiveness of medical services, the development of practice guidelines, and improvements in utilization review and quality assurance.

Let me describe these recommendations in a little more detail.

First, the fee schedule: It replaces the customary, prevailing and reasonable payment system currently in effect. It is primarily based on the resource costs of providing services. It is based on relative values that include both physician's work and practice costs. A dollar conversion factor converts the RVS, which includes approximately 7,000 separate codes defining specific services and procedures, to a fee schedule. It should be revenue neutral at its outset. A geographic multiplier is then used to account for the different overhead costs in different geographic areas.

The relative value scale includes both the physician's work and the overhead costs of practice. The Commission is using the method developed by Prof. William Hsiao and his associates at Harvard to describe the work of the physician, with modifications by Dr. Hsiao and by the Commission. The most important modifications by the Commission include the establishment of global fees for surgical services, the incorporation of time in addition to other factors in evaluation and management service codes, and an improved method for determining practice costs.

Practice costs will initially be calculated by specialty, but this method will be superseded by estimates of practice costs by type of service when the data is available. The Commission also recommends a separate cost of practice calculation for professional liability premiums.

The Medicare fee schedule RVS should be updated annually. We believe that the process followed by the Commission during the past 2½ years is an effective one to deal with the update. The medical profession certainly has a key role to play in this process.

Specialty differentials can be eliminated under the proposed Medicare fee schedule. The grouping of codes mandated by Congress for January 1, 1990, should be postponed. The abuse and misuse of the coding system can be better handled by the proposals that we are recommending.

Mandatory assignment was recommended for qualified Medicare beneficiaries, QMB's. Because the Commission considers QMB's to be Medicaid beneficiaries, we believe should be covered by the same assignment policies as dual eligibles. Mandatory assignment on all unassigned claims was not recommended. Although a number of Commissioners favored this policy, the majority do not support it at this time. Our balance alludes to Medicare precedents for a balance billing limit of 115 to 125 percent on unassigned claims.

It was recommended that the PAR program be continued. It currently provides for a 5 percent differential in the payment to PAR physicians.

A transition fee schedule, to go into effect on April 1, 1990, is recommended. The transition fee schedule would modify the current prevailing charges in the direction of the resource-based fees that will be adopted when the Medicare fee schedule is implemented in 1991. Thus, the fees for evaluation and management services would increase, and the fees for many procedures would decrease.

The impact of the proposed changes on physicians and beneficiaries are shown in tables 1 to 4 attached to our testimony submitted for the record. table 1 described changes in selective services; table 2, the impact on specialties; table 3, the urban/rural impact; and table 4, the impact on beneficiary coinsurance and balance billing.

Next, let me talk about policies to slow expenditure increases. The Commission recommends a national expenditure target. The rate of increase projected from year-to-year would be based on three factors: practice costs, the increase in the number of beneficiaries, and the desired increase in volume of services. Those would each be percentage increases.

There would be an annual update. If expenditures in any 1 year exceeded the targets, the fees in the subsequent years would be reduced a proportionate amount. If the expenditures were below the target, the fees could be increased a proportionate amount.

We believe that there might be an evolution from the national expenditure target to multiple targets; for example, at the State or carrier level, or perhaps by specialty such as surgery or medical services.

The expenditure target would initially include physician expenditures under part B only. Subsequently, it might include all of part B expenditures, and perhaps hospital admissions at a later date.

A second strategy for reducing the rate of increase in Medicare expenditures falls under the general description of effectiveness research and practice guidelines. The Commission strongly applauds the initiative that was started last year by Dr. Roper. This area has been examined very carefully by the Institute of Medicine. They have made major recommendations in the area as have others.

We believe that an expansion in this area to identify what services are effective will be a critically important element. This can include clinical effectiveness research and health services research including things like cost effectiveness studies. It would include the Health Care Financing Administration, the National Center for Health Services Research, the National Institutes of Health, which have been very important in the consensus conferences.

The medical profession will play a critical role in the development of practice guidelines, and we believe there are a number of areas where practice guidelines can move from their current status as an educational tool to a device that can be used to more effectively control utilization. Guidelines should be utilized more appropriately at the carrier and PRO level. We also hope that expenditure targets will encourage the medical profession to be more involved with the Health Care Financing Administration, carriers, and PRO's in utilization and quality reviews.

A third and very important area to develop is an infrastructure for payment reform. We applaud HCFA's efforts to introduce a unique physician identifier and to incorporate diagnostic information on part B claim forms, and to develop a common working file including part A and part B claims data.

We also believe that it would be important to require providers to submit all claims. This would provide for much more accurate claims data. It would also be a service to beneficiaries.

We believe that the Congress should urge HCFA to accelerate the trend toward electronic claims processing. It is not feasible to do that universally now, but some carriers are doing more to promote electronic submission than others.

Finally, we believe in this area that there must be adequate funding for HCFA and carrier medical reviews and for other infrastructure activities. If we are going to institute the kind of reforms that we are proposing, you have to have a management capacity at both the HCFA level and carrier level.

Finally, we make recommendations with respect to capitation. Congress had earlier enacted provisions to prohibit HMO's and

CMP's from using financial inducements to reduce or limit medical services. These prohibitions were to go into effect in 1990. We believe these can and should be modified. First, a limit on total risk assumed by physicians should be established through some form of stop loss. Second, the incentives in these organizations should rely primarily on incentives to groups of physicians, not individual physicians. We believe also that there should be disclosure by HMO's or the other organizations to both physicians and beneficiaries, of appropriate information on their risk-sharing arrangements.

Mr. Chairman, this represents a brief summary of the information that is provided in greater detail in the testimony and will, of course, be provided in much greater detail in our report which will be submitted next month.

Thank you very much.

[The statement of Dr. Lee follows:]

Statement of
Philip R. Lee, M.D.
Chairman
Physician Payment Review Commission

The Physician Payment Review Commission has developed proposals to rationalize the pattern of payments to physicians by Medicare and to slow the rate of increase in program costs so that they are affordable to the beneficiaries and the taxpayers. It met last week and approved the recommendations to be included in its 1989 Report to Congress, which will be submitted by April 30. I appear before you today to discuss these recommendations and answer your questions.

To rationalize the pattern of payments by Medicare, the Commission proposes a Medicare Fee Schedule based primarily on resource costs. To limit beneficiary financial liability, it recommends limits on balance billing. To control growth in expenditures, the Commission proposes the use of expenditure targets and increased research on effectiveness of medical services and development of practice guidelines.

MEDICARE FEE SCHEDULE

In its report to Congress two years ago, the Commission called for the development of a fee schedule for Medicare. We are now proposing that the current CPR method for paying physicians be replaced by a Medicare Fee Schedule that is based primarily on resource costs. The Commission recommends enactment of legislation this year to establish a Medicare Fee Schedule, with a transition fee schedule implemented within six months of enactment to move the payment system in a series of steps toward full implementation of the Medicare Fee Schedule in 1992. The Commission also recommends that the Medicare Fee Schedule should include all specialties, including radiology and anesthesiology for which separate fee schedules now exist for Medicare payment.

A fee schedule consists of:

- a relative value scale (RVS), which indicates the value of each service or procedure relative to others,
- a conversion factor, which translates the RVS into a fee for each service, and
- a geographic multiplier, which indicates how payment for a service is to vary from one geographic area to another.

Relative Value Scale

The Commission has reached a number of conclusions about the design of the relative value scale for the Medicare Fee Schedule. I will briefly describe our recommendations and then provide some background for the Commission's decisions.

The Commission recommends that the relative value scale (RVS) be comprised of two cost elements: relative physician work and practice costs.

With respect to relative physician work, the Commission favors:

- the use of the Hsiao methodology for estimating relative physician work, with refinements based on current work by Dr. Hsiao and analyses currently underway by the Commission
- adoption of a policy developed by the Commission to standardize the definition for all surgical global services, and
- modification of the current coding system for evaluation and management services to incorporate time into the definition of visit codes

For practice costs, the Commission proposes:

- use of a Commission-developed additive formula for incorporating practice costs into the RVS
- initial use of the Commission's refined estimates of practice costs by specialty, to be superceded by estimates of practice costs by category of service.
- developing a separate practice cost factor for professional liability insurance premiums

Relative Physician Work. The Commission has carefully evaluated the pioneering work by William Hsiao and his colleagues at Harvard University to develop a resource-based relative value scale. As have others, the Commission has found the methodology for estimating relative physician work to be sound and has drawn heavily on it in developing its RVS for the Medicare Fee Schedule. The Commission's evaluation calls for additional research to be undertaken by Dr. Hsiao and the Commission staff to strengthen the results of the study. Most of these tasks are already underway.

A national fee schedule requires that the codes for physician services be interpreted uniformly by all physicians and carriers. Only then can accurate relative values be assigned to each service so that fees reflect the resource costs associated with providing that service. The Commission's recommendations call for changes related to coding in two important areas: surgical global fees and evaluation and management services.

Codes for Surgical Global Services. With the unanimous agreement of a consensus panel made up of surgeons and carrier representatives, the Commission has developed a policy defining which services associated with an operation are to be included in the global payment for surgery and which are to be paid separately. Using data from the Hsiao study, the Commission has calculated the relative values for each operation to conform to this policy.

Codes for Evaluation and Management Services. Physicians cannot accurately use the current codes for evaluation and management services (commonly referred to as visit codes) to reflect their time and work, because the levels of service (e.g., brief, intermediate, comprehensive) are not precisely defined. Therefore, it is difficult to assign accurate values to current visit codes in a resource-based fee schedule. Analysis by the Commission and by Dr. Hsiao and his colleagues suggests that the physician's time is a good predictor of the work involved in each type of visit (e.g., hospital visit, office visit, new patient, established patient). The Commission recommends that time be incorporated into the definitions for visit codes. This coding reform would allow more accurate relative values to be assigned to these services and help physicians use the codes properly. Carriers would also have a way to determine whether physicians were billing correctly for these services.

With work currently underway by the Commission, Dr. Hsiao and the AMA-sponsored CPT Editorial Panel that oversees the CPT coding system, we expect definitions for visit codes to be revised and individual relative values to be assigned within the next year, well before full implementation of the Medicare Fee Schedule.

Grouping of Codes. Given the work currently underway to modify the coding system for the Medicare Fee Schedule, the Commission recommends the postponement of the legislative mandate to "group codes for payment purposes" by January 1, 1990.[1] The goal of this mandate is to control misuse and abuse of the coding system under the current payment method. Analysis by the Commission suggests that this could be accomplished more effectively by integrating precise definitions for codes with more rational fees for physician services.

Practice Cost Formula. The Commission has developed a formula for incorporating practice costs into the RVS that allows for overhead to be calculated independently from physician work. The original formula developed by Dr. Hsiao allowed changes in estimates of physician work to affect the calculation of overhead. This distorted the relative values and led to an overestimate of the impact of the shift to a fee schedule. As a result of the Commission's correction in the formula, the magnitude of changes in fees and impacts on different specialties is almost halved from the preliminary estimates reported by Dr. Hsiao and his colleagues last summer.[2] From our discussions with Dr. Hsiao, we understand that he agrees with the Commission's modification of the formula.

Professional Liability Insurance. Insurance coverage for professional liability represents a major cost to physicians that varies substantially by specialty and geographic area. To assure that the fee schedule adequately accounts for differences among risk classes (e.g., physicians doing no surgery versus thoracic, vascular and orthopedic surgeons) and localities (e.g., Florida, Idaho) used in setting premium rates, the Commission recommends that professional liability insurance premiums should be treated as a separate practice cost factor.

Updating the Relative Value Scale. Revisions in the relative value scale will be required to account for the introduction of new technology, changes in the use of existing technology and in clinical approaches to care, and refinements in the coding system. The Commission recommends that the process used to develop the Medicare Fee Schedule, in which the Commission provides the Congress with the information and advice it needs to make policy decisions, be used for updating the relative value scale. That process has been successful in accomplishing the technical and policy development tasks required, and it provides substantial opportunity for organizations representing physicians, beneficiaries and others affected by the policy to participate in the decision-making process.

Physicians, in particular, have a major role to play in revising the relative value scale. The Commission will continue to work closely with the American Medical Association (AMA) and the specialty societies. If the medical profession decides to coordinate its input on updating the relative value scale through the AMA, the Commission would find that an acceptable process.

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[1] Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Section 9331 (d)(2).

[2] Hsiao, et al., "Results and Policy Implications of the Resource-Based Relative Value Study," The New England Journal of Medicine, 319 (13): 881-888 (September 29, 1988.

Conversion Factor

The conversion factor transforms the RVS into a schedule of dollar payments for each service. The Commission recommends that the initial conversion factor be set so that outlays for physicians' services projected under the fee schedule are the same as those projected under the current payment system.

The conversion factor should be updated annually. The formula used to determine the update should have as one element the difference between targeted and actual expenditures. I will describe how the formula would be used when I turn to expenditure targets.

Geographic Multipliers

The Commission recommends that the geographic multiplier reflect only variation in overhead costs of practice. The amount physicians receive for their time and effort, after subtracting overhead costs, should not vary by locality. Therefore, if physicians in two parts of the country provide the same quantity and mix of services to Medicare beneficiaries, they would receive the same net income from Medicare. This policy would reduce substantially the magnitude of geographic variation in fees.

Specialty Differentials

The Commission recommends that when a service provided by physicians in different specialties is essentially the same, the payment should be the same. Therefore, specialty differentials -- differences in payment to physicians of different specialties for the same procedure code -- would be eliminated under the fee schedule.

In some cases, physicians in different specialties provide different services under the same code, and yet receive the same payment, because distinct codes that would accurately capture these differences do not exist. These legitimate differences, when substantiated, should be recognized by establishing new codes. Identification of such coding changes would be part of the process for updating the relative value scale.

Assignment and Balance Billing

The Medicare Fee Schedule must be accompanied by policies to limit beneficiaries' financial responsibility for charges in excess of what Medicare allows. The Commission does not recommend mandatory assignment but proposes the following set of policies that together provide increased protection for beneficiaries:

- limitations on charges for unassigned claims to a fixed percentage of the fee schedule amount. These charge limits would replace current MAAC limits. Federal legislation in recent years has set two precedents for the amount of balance billing allowed. In one (overpriced procedures), the charge limit, after a phase-in period, was set at 125 percent of the Medicare allowed amount; in the other (the radiology fee schedule), the limit will be phased in to 115 percent.
- elimination of balance billing for qualified Medicare beneficiaries. This requires clarification of the provision in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) that requires state Medicaid programs to pay Medicare cost sharing for beneficiaries seeking this assistance who are not otherwise eligible for Medicaid, but who have incomes below the federal poverty level. The current legislation covers Medicaid payment of deductibles, premiums and coinsurance, but does not require physicians to accept the Medicare allowed charge as payment in full, as they do for other Medicare beneficiaries covered by Medicaid.
- continuation of the Participating Provider Program and its payment differential that provides higher fees to participating physicians.

The Commission has concluded that the market for physicians' services does not function well enough to preclude the need for financial protection for Medicare beneficiaries. Without limitations on balance billing, beneficiary financial protection would suffer. On the other hand, the Commission does not recommend mandatory assignment. Limited balance billing would provide a safety valve concerning errors in setting fee schedule amounts and an opportunity for those physicians who are especially highly regarded by patients or who systematically take on the most difficult cases to be paid more than the fee schedule amount.

Impact on Physicians and Beneficiaries

The Commission has constructed simulation models to project the impact of the Medicare Fee Schedule on categories of physicians and beneficiaries. Table 1 shows the changes in Medicare payments for selected services. Note that fees for evaluation and management services, such as office visits and hospital visits, would increase and fees for many surgical procedures would decrease. Table 2 shows the impact on major specialties included in the first phase of the Hsiao study. Medicare payments would increase for family physicians and internists and decrease for thoracic surgeons, ophthalmologists, and radiologists.

The Medicare Fee Schedule would change the distribution of payments among geographic areas (Table 3). Using a geographic multiplier that reflects overhead costs only, payments to physicians in rural areas would increase. Those to physicians in very large metropolitan areas would decrease.

Table 4 shows the impact on out-of-pocket payment of coinsurance and balance bills for different categories of beneficiaries. All of the categories identified would experience a moderate reduction in costs, most of which would result from the limit on balance billing. Indeed, the percentage reductions in balance billing alone are much larger. The magnitude of these reductions is relatively uniform across the different categories of beneficiaries.

Transition

The Commission recommends a transition from the current payment system to full implementation of the Medicare Fee Schedule. This would give physicians and beneficiaries time to adjust, allow for midcourse corrections, and increase the chances that private payers will change their policies as Medicare changes are being implemented.

The transition must be designed to avoid disruption of the administration of the program by carriers. The Commission's plan would create a Transitional Fee Schedule that would retain customary and prevailing charge screens. It would base changes in prevailing screens on the difference between current payments and those projected for the Medicare Fee Schedule.
A projected fee schedule amount would be calculated for each service and procedure. Services would be grouped into categories that are relatively homogeneous, such as office visits and major operative procedures. For each category, the percentage difference between the fee schedule amount and the average allowed amount under current policy would be calculated.

For the first year of the Transitional Fee Schedule, the prevailing charge of each procedure would be changed by one-fifth of this percentage difference. Thus, for example, if office visits are to increase by 25 percent under the Medicare Fee Schedule, the prevailing charge for each type of visit would increase by 5 percent during this first year. For the second year of the transitional fee schedule, prevailing charges would be adjusted by an additional one-fourth. Comparable geographic adjustments to prevailing charges would also be included. We have discussed this approach with knowledgeable experts since the Commission meeting and expect to make refinements based on their advice.

Implementation of the Transitional Fee Schedule would begin about six months after enactment of the legislation. After two years of experience, the full Medicare Fee Schedule would be implemented. At this point, coding reforms and changes in locality boundaries would be implemented. In addition, prevailing and customary charge screens would be eliminated so that all services would be paid at the fee schedule amount.

POLICIES TO SLOW INCREASES IN EXPENDITURES

From 1980 to 1988, Medicare outlays for physician services tripled. Premiums now amount to $334.80 per year. Neither the taxpayers or the beneficiaries can afford continued increases of this magnitude. Decisive steps to slow these increases are needed now.

The preferred way to contain costs is to reduce the provision of those services that are unnecessary and inappropriate. In this way, access and quality of care would not be sacrificed in the course of slowing expenditure growth.

The Commission recommends that three policies be pursued:

- o giving physicians collective incentives to contain costs through expenditure targets,
- o increased research on effectiveness of care and development and dissemination of practice guidelines,
- o improvements in utilization management by carriers and peer review organizations (PROs).

Expenditure Targets

The Commission recommends that a national expenditure target for physicians' services under Part B be used to determine annual conversion factor updates under the fee schedule. The target would reflect increases in practice costs, growth in the number of enrollees, and a decision concerning the appropriate rate of increase in volume of services per enrollee. The last would reflect tradeoffs between beneficiary needs, technological advances, and affordability.

If actual expenditures during a year are equal to targeted expenditures, then the conversion factor update for the following year would be equal to the increase in practice costs. The update would be increased or decreased to reflect differences between actual and targeted expenditure increases.

As an example, assume that practice costs are increasing by 4 percent, enrollment is growing 2 percent, and volume of services is projected to increase by 7 percent per enrollee. This would lead to a 13 percent increase in expenditures. Now assume that a target of 11 percent is chosen, which would permit a volume increase of 5 percent. If actual expenditures rise 13 percent, then the conversion factor update for the following year would be 2 percent (4 - 2). If actual expenditures rise only 9 percent, then the conversion factor update would be 6 percent (4 + 2).

Expenditure targets are designed to stimulate efforts by the medical community to work with the Medicare program to increase knowledge of the effectiveness of services and to use this knowledge to increase the appropriateness of care. Encouragement would come from tying the annual update in the Medicare Fee Schedule conversion factor to the difference between the rate of increase in expenditures for physicians' services and the target rate of increase.

In order to allow time for the necessary infrastructure to control costs to develop, the Commission recommends that target rates of increase for the first few years not depart substantially from baseline rates of increase.

The Commission recommends beginning with a single target at the national level, but anticipates that the policy will evolve to one with multiple targets. For example, targets could be established for states or carrier areas or for categories of services (for example, separate targets for surgery and other services). Broadening the target to include the rate of hospital admissions is another possible direction. The Commission has already studied several of these options and will continue to do this work.

Expenditure targets would not alter the financial incentives for individual physicians and their patients. Rather, the incentives would fall to the physician community, which could respond through education and support of the existing infrastructure of medical review. For example, the American Medical Association and national specialty societies could develop practice guidelines and disseminate them. They could provide technical assistance to carriers and PROs in the development of criteria for review and political support for sanctions of physicians who persisted in providing care that is inappropriate and does not meet standards of quality.

Effectiveness Research and Practice Guidelines

The Commission recommends a substantial increase in federal support for building our knowledge of the effectiveness and appropriateness of medical practices and getting that knowledge to practicing physicians and their patients. We need to know more about which of our diagnostic tools work, and which patients would benefit from particular therapy. This knowledge is essential if we are to reduce unnecessary and inappropriate services.

To increase this knowledge, we need more research to determine the medical outcomes and the costs of alternative medical practices and procedures, and to determine the best ways to organize and provide care. This work would include clinical trials, epidemiological studies of data generated by clinical practice, analyses of the cost-effectiveness of alternative ways to organize care, and assessment of techniques used in managed care to influence physicians' clinical decisions.

The knowledge we have about effectiveness and appropriateness must be made available to physicians and their patients. Practice guidelines synthesize the best that we know from research and the judgments of practicing physicians, into a form that can be readily used. The Commission recommends that the federal government actively encourage the development and dissemination of practice guidelines so that they are incorporated into physicians' practices, made availble to patients, and used as the basis for coverage and payment, and for medical review criteria by hospital medical staffs, carriers, and PROs.

The Commission calls for the federal government to support practice guidelines through funding, coordination and evaluation. Funds should be used to support and build on existing private sector activities by the medical profession and others. Federal oversight should focus on insuring the integrity of the process, including the quality of the methods used and of the resulting guidelines, and facilitating efforts among those involved in developing the guidelines to share information, identify issues and set priorities.

The federal government also has a role as administrator of Medicare. The Health Care Financing Administration should reinforce the importance of basing medical review on sound criteria by assisting PROs and carriers in selecting and using review criteria that are consistent with practice guidelines.

Utilization Review

The Commission supports the current efforts by HCFA to move toward a more comprehensive approach to medical review and calls for further actions to strengthen the review process.

If utilization and quality review are to be effective tools both to improve the quality and efficiency of care and to control the growth in Medicare expenditures, the Medicare program will have to create a comprehensive medical review system that looks beyond individual services to complete episodes of care. This requires systematic integration of information drawn from claims data, analysis of practice variations and peer review of physician practice.

To take on these responsibilities, it is essential that carriers and PROs have additional resources and time to build the necessary capacity. It will also require more administrative flexibility and the cooperation of the medical community. The Commission will discuss in its forthcoming report a number of specific recommendations to structure and focus the transition from the current system that has emphasized claims payment to one of comprehensive review.

INFRASTRUCTURE FOR PAYMENT REFORM

Successful implementation of the payment reforms described above will require investments in the administrative infrastructure of Medicare. We applaud recent efforts by HCFA to introduce a unique physician identifier, to incorporate diagnostic information on claims forms, and to develop a common working file including data from both Part A and Part B.

The Commission recommends two further changes to strengthen the ability to implement these payment reforms. First, Medicare should require providers to submit all claims, whether or not assignment is accepted. Second, HCFA should take steps to accelerate the trend towards electronic claims submission. The ability of the carriers to implement a fee schedule and expand their medical review activities is dependent on funding that is adequate and predictable. Unfortunately, this cannot be taken for granted. While funding for medical review activities of carriers was increased for the current fiscal year, the President's budget for 1990 would cut funding by 19 percent. In a program trying to hold back outlay increases in the range of $4 billion per year, attempts to shave spending for administration (in particular, medical review) are poorly conceived. If we are to attempt major reforms in this program, we must assure that the administrative resources are there to carry them out.

CAPITATION

Some have expressed concern that certain types of prepaid health plans have failed to establish strong organizational structures and management systems and instead have relied heavily on financial incentives to physicians to control costs, posing a risk of underservice to enrollees. This concern led Congress in 1986 to prohibit HMO and CMP use of financial inducements to physicians to reduce or limit service to Medicare beneficiaries. The provision was not scheduled to take effect until 1990 in order to permit time to substitute a less sweeping limitation.

While use of financial incentives to physicians raise important concerns regarding patient care, broad prohibitions may not be in the interest of Medicare beneficiaries. First, we have no definitive information concerning whether or not risk-sharing arrangements now have an adverse effect on access or quality. Second, such restrictions could result in the termination of many HMOs' risk contracts with Medicare and reduce beneficiaries' access to prepaid plans. Medicare beneficiaries comprise a very small proportion of HMO enrollment, so restrictions on practices that HMOs consider important to their success could lead many to turn away from the Medicare program.

The Commission has developed proposals to restrict only the more problematic forms of financial incentives. It recommends that health plans limit the total risk assumed by physicians through some form of reinsurance or "stop loss" provision and that they rely primarily on incentives to groups of physicians rather than to individual physicians. Health plans should also disclose to both physicians and enrollees appropriate information on risk-sharing arrangements.

In addition to limitations on the use of financial incentives, the Commission recommends efforts to strengthen Medicare's external review processes applicable to prepaid plans and the conduct of periodic surveys of beneficiary satisfaction. Finally, the Commission recommends additional research to identify the effects of patient characteristics on the use of services and on the impact of risk-sharing arrangements on physician behavior.

CONCLUSION

Three years ago the the Congress created this Commission with a mandate to suggest policies to rationalize the payment for physicians' services by the Medicare program and to slow the rate of growth of expenditures for these services. We believe that a Medicare Fee Schedule will serve to rationalize payments by tying them to resource costs. It will be simpler and easier to understand for both physicians and beneficiaries. It will promote better care and provide additional financial protection for beneficiaries. Expenditure targets will help slow the increase in Medicare expenditures so that we as a society can meet other pressing social needs. And increased effectiveness research and practice guidelines will provide us with the knowledge and means to manage available health care resources more wisely. With these changes, we believe that Medicare can continue to meet the medical needs of our elderly and disabled citizens.

Preliminary
March 15, 1989

Table 1. **National Mean Allowed Charges in 1988 for Selected Procedures - Medicare Fee Schedule and CPR System -**

		MFS $	CPR $	CHANGE %
Internal Medicine				
	OFFICE VISITS			
90050	limited	28.3	22.8	24.2
90060	intermediate	35.3	28.0	26.2
	HOSPITAL VISITS			
90250	limited	33.3	25.9	28.5
90260	intermediate	40.1	29.7	34.8
	Other			
90620	comprehensive consultation	104.4	92.7	12.6
93000	electrocardiogram,complete	24.6	34.9	-29.5
71020	x-ray exam of chest	28.8	37.9	-23.9
Ophthalmology				
66984	remove cataract, insert lens	1163.3	1467.1	-20.7
92014	eye exam and treatment	39.4	41.7	-5.5
Orthopedic Surg.				
27130	total hip replacement	1954.5	2404.0	-18.7
27236	repair femur fracture	1187.4	1302.3	-8.8
27244	repair femur fracture	1188.0	1299.3	-8.6
General Surgery				
35301	rechannel of artery	1154.1	1573.4	-26.6
44140	partial removal of colon	1064.8	1255.8	-15.2
49505	repair inguinal hernia	405.0	587.9	-31.1
Urology				
52000	cystoscopy	111.1	104.9	5.9
52601	prostatectomy (TUR)	919.9	1128.0	-18.5
Radiology				
70470	contrast CAT scans of head	77.6	112.9	-31.3
71020	x-ray exam of chest	16.9	14.7	15.1
Thoracic Surgery				
33512	coronary artery bypass	2815.6	3894.4	-27.7

Table 2. **Percent Change in Medicare Allowed Amounts by Specialty Under Medicare Fee Schedule Compared to CPR System**

SPECIALTY	PERCENT CHANGE
Medical	
Internal Medicine	17.5
Family Practice	39.6
Dermatology	1.0
Surgical	
Ophthalmology	-16.4
General Surgery	-10.5
Orthopedic Surgery	-7.7
Urology	-4.0
Thoracic Surgery	-19.2
Otolaryngology	6.8
Obstetrics/Gynecology	0.6
Hospital Based	
Radiology	-25.3
Pathology	-24.2
Anesthesia	na
Other Physicians	4.9

Table 3. **Percent Change in 1988 Medicare Allowed Amounts by Area Under Medicare Fee Schedule Compared to CPR System**

AREA[1]	SPECIALTY GROUP	PERCENT CHANGE
Very Large Metro	Medical	-1.2
	Surgical	-25.6
	All physicians	-14.3
Large Metro	Medical	17.4
	Surgical	-12.2
	All physicians	-3.0
Other Metro	Medical	26.4
	Surgical	-7.0
	All Physicians	3.0
Large Rural	Medical	31.5
	Surgical	-5.5
	All Physicians	12.8
Other Rural	Medical	38.4
	Surgical	-8.8
	All Physicians	15.1

[1] *Very Large Metro areas include counties in MSAs of 5 million or more populations, large metro includes counties in MSAs of 1 million to 5 million population, other metro area are all other metropolitan counties.*

Large rural (non-metropolitan) counties have population of 25,000 or more, other rural includes all other non-metropolitan counties.

Table 4. **Change in Mean Beneficiary Coinsurance plus Balance Billing for Medicare Part-B Physician Services 1988 Under Medicare Fee Schedule Compared to CPR System - 120% Balance Bill Limit -**

BENEFICIARY CATEGORY	EXPENSES IN DOLLARS AND AS PERCENT CHANGE FROM BASELINE		
	CPR BASELINE	MFS	
	$	$	%
All	216	163	-25
< 65 yrs	194	154	-21
65 - 74	214	157	-27
75 - 84	232	177	-24
85+ yrs	191	136	-19
Males	239	178	-25
white	246	182	-26
non-white	164	135	-18
Females	200	152	-24
white	209	158	-24
non-white	122	102	-16
Area			
very large metro	281	193	-13
large metro	233	180	-23
other metro	213	161	-24
large rural	186	143	-24
other rural	176	133	-25
Income			
poor	108	85	-21
near poor	194	148	-24
1.6 - 2.0 x poverty	210	162	-23
2.1 - 3.0 x poverty	237	180	-24
> 3.0 x poverty	263	192	-27
Hospitalized during year			
Yes	543	408	-25
No	116	88	-24

Chairman **Stark**. Thank you very much, Phil.

There is, I presume, nothing in your proposal that requires us to make it budget neutral. In other words, it seems to me that rather than taking the savings from reducing overpriced procedures and giving those savings to the underpriced procedures, we could hold the size of the pie constant, if you will, which would be a major budget savings to us; and thereby use your program to effect some budget savings and implement the increases more slowly. Is that not correct?

Dr. **Lee**. With a transition fee schedule, we anticipate moving toward a Medicare fee schedule by 1992. Clearly, it is the Congress who will make that determination. The Commission will make its recommendations, but Congress must make that decision. Changes would also be feasible before the transition because the Commission will develop sufficient detail for the Congress to decide which procedures to reduce the values for.

Chairman **Stark**. I do not think we want to make those decisions. I am just saying that we could use your system intact.

Dr. **Lee**. That could be done, correct.

Chairman **Stark**. But to have budget savings, it does not have to be budget neutral to operate?

Dr. **Lee**. It does not have to be budget neutral.

Mr. **Ginsburg**. There certainly could be budget savings. I would not advise going so far that there are only reductions and no increases for other procedures. I think that would destroy much of the intent.

Chairman **Stark**. It would not be popular. That would have some political fallout. It would probably be great for the budget. I do not think it is likely to happen, but I am just suggesting that there is nothing sacred about neutrality that would violate the principles of your system.

Mr. **Ginsburg**. That is right.

Chairman **Stark**. Relative to our ability to control overall costs and relative to the equity, could you comment, Phil, on the differences between the proposals that we will hear from the American Medical Association and the American College of Surgeons? Both proposals are going to be before us today, and I know you are acquainted with them. How do they differ, and what is your feeling about their usefulness in controlling costs?

Dr. **Lee**. I can only speak from the standpoint of the testimony that was presented to the Commission.

It is my understanding that the AMA supports the development of a resource-based relative value scale and a national fee schedule based on that. The belief that using the resource cost approach will have a moderating effect on the rate of increase in costs. That is obviously a judgment call.

The AMA has opposed expenditure targets and has opposed limits on balance billing. We would be concerned that without these constraints you could have unanticipated increases in expenditures. Although we have had people testify before us about what is the likely impacts, nobody can predict with great accuracy what those changes might be. So we think that no limit on balance billing would be likely to produce some unintended cost increases for beneficiaries.

The College of Surgeons has proposed a rather different approach, what they call a blended fee schedule with a separate expenditure target for surgery. Basically, that would provide, if the details could be worked out a way to constrain the rate of increase. But the proportion of expenditures that go to surgery would remain the same.

In other words, if you take a rectangle and draw a line through it at the 50 or 60 percent level, that is what now goes to surgery. That would include multiple surgical specialties. That would not correct what we consider to be the perverse incentives in the present payment system. The reason we think there should be a resource-based fee schedule is that it levels the playing field so that the incentives are no greater to perform a procedure than they are to provide a visit.

Chairman STARK. What you are saying is that the surgeons indicate that if they are now getting 60 percent of Medicare funds, whatever we do they should continue to receive 60 percent; the others should get 40.

Dr. LEE. They should at least start out with that piece, and they would then control the growth in that piece.

Chairman STARK. Would there be any problem if that was something that the surgeons negotiated with the other doctors? In other words, my own guess is that I do not think this is something Congress wants to get into. In your opinion, is there any problem if various specialties within the medical fraternity try to negotiate among themselves? Could they say, well, this is the way we are going to bargain: the internists are going to get 20 percent because that is what they got last year?

Do you expect over the long run that the changes in practice will have more effect on the shares of the pie?

Dr. LEE. First of all, we think the payment system must be reformed. We think the present system has got such perverse incentives and is seriously flawed. It is inflationary. Unless you correct that, how you divvy it up does not make that much of a difference.

Down the road, we would like to consider expenditure targets by specialty. We do not know that it is feasible. We have not seen enough information. We would like to start with a national target because we know, or at least we believe, that is feasible with what we know now.

We would also like to examine options for targets at the State or carrier level. We have not developed this idea sufficiently to say that is feasible. At that level, it might be possible to have different targets for medicine and surgery. But I do not see negotiation going on within the medical profession to settle that at the present time.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman.

Dr. Lee, I want to make sure I understand the relationship between the relative value scale fee schedule and the overall cap. How does one mesh with the other? How do we determine what the overall cap will be? How does this relate to our reimbursement system for hospitals, which is more based on a market basket approach?

Could you comment on those questions, please?

Dr. LEE. There is not a direct relationship, to the hospital payment system. The resource-based relative value scale includes two components the work of the physician, and then the overhead cost of the physician's practice. We would separate out malpractice because, it varies significantly by geographic area and specialty.

With the work that Dr. Hsiao is doing and that we are doing now, we feel confident that we can develop a relative value scale for the 7,000 procedure and service codes that are used in payment in the Medicare program. Once that is established, it can be converted into a fee schedule. The fee schedule will deal with the price side of the volume/price equation which results in expenditures.

To deal with the volume piece of the equation, we have recommended an expenditure target concept. It would include three components—practice costs, increases in the number of beneficiaries, and the desired increase in the volume of services. Now, let us say, for example, that practice costs increase 6 percent next year projected to increase 6 percent. The number of beneficiaries will increase by 2 percent. So there is 8 percent. If at current rates you project an increase of volume of 7 percent, you would have a 17-percent increase in expenditures next year.

That maybe more than we want to spend. Let us make the target, instead of 17 percent, 15 percent. That means that either the volume has to come down by 2 percent to achieve that target, or fees must be proportionately reduced to achieve the 15 percent target.

We believe that by setting a target that is not too dramatically different from current levels, you send out a signal and encourage the medical profession to be much more actively involved in dealing with the problems of volume. Volume is the area that has been the most difficult to deal with, and it is still the most difficult to deal with.

Mr. CHANDLER. That is what I am not clear on. How do you send that signal? How do you get that individual physician to make the decision, or the patient not to seek the service?

Dr. LEE. We are not trying to constrain the individual doctor, but we are trying to provide information to the physician so they can make better judgments. We do not think that the Commission, Congress, or HCFA can say to the individual physician do this or do that. We think that the profession should be much more actively involved in the development of practice guidelines and research on the effectiveness of services.

Some studies suggest that in some areas as many as 20 to 30 percent of the procedures performed are either unnecessary or of marginal benefit. If we could eliminate or reduce those, we could save all the money we need to finance with Medicare and still have some left for other things that need to be done.

Mr. CHANDLER. So it is the Commission's view that overreimbursement is not so much the problem but overutilization.

Dr. LEE. Volume has been the most difficult one to control. Unfortunately, the problem is that the incentives within the current payment system encourage procedures as opposed to caring for or spending time with patients. The Commission feels that these incentives must be corrected in order for Medicare to provide a more appropriate mix of services.

Mr. CHANDLER. The question I have is: Is the physician going to be the one that will be the most effective in discouraging that overutilization? We have often been told that if people had to pay for the health care themselves, then they would be less apt to utilize these services. And at the same time, we are limiting the amounts or suggesting that we limit the amount that the physician can bill beyond Medicare, the so-called copayment idea.

If we do not reach that patient, if we do not discourage the patient from seeking this treatment, how the heck are we going to control the utilization?

Dr. LEE. There are several ways, but it is a complex situation. With respect to out-of-pocket payments, the patient now pays a premium and 20 percent coinsurance on all services they receive from physicians.

There is really conflicting evidence about whether an additional payment at the time of service would be a deterrent to necessary care, or whether it would be a deterrent to inappropriate care. And I do not think we have good answers on that from the studies that are currently available.

Paul, do you want to add anything to that?

Mr. GINSBURG. No, I think you have covered it well.

Mr. CHANDLER. In terms of some of the very expensive procedures, the kinds of heart operations that we seem to be finding less expensive procedures, do you think that the medical community is moving in that direction? Or do they need to be pushed a bit?

Dr. LEE. I think that using a resource-based relative value scale as the basis for a fee schedule will provide more appropriate incentives for physicians. But I think the doctors are the only ones who can make these changes.

I think that there is, in many ways, too much external regulation. For example, managed care and various other kinds of organizations telling doctors what they can and cannot do. I would hope that the medical profession would be encouraged to take more responsibility through the approaches that the Commission is proposing.

There are two deterrents to doctors doing that. One is the concern over malpractice and the second is the threat of violating antitrust laws. The Attorney General's Office and the Federal Trade Commission have been studying the antitrust issue. It is a fine line sometimes. When groups of doctors get together to develop standards of care, for example, are they in collusion in restraint of trade, when, in fact, they are trying to improve quality and diminish inappropriate care?

This is an area that is going to require more examination to determine whether some limits should be placed on antitrust actions against physicians.

Mr. CHANDLER. Thank you, Mr. Chairman.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

Dr. Lee, I noticed in your recommendations on assignment and balance billing, you do not recommend mandatory assignment, but you do recommend limiting charges on unassigned claims to a fixed percentage.

Did you set the percentage? Do you make a recommendation of the percentage?

Dr. LEE. No, sir. Congress has already set limits on balance billing in two different situations. In the radiology fee schedule, it has set a limit on balance billing starting at 125 percent the first year, 120 percent the second year, and 115 percent the third year. And I believe that the radiologists have agreed to that.

Also, there is a 125-percent limit on balance billing for overpriced procedures.

Mr. PICKLE. Has any group besides radiologists agreed to that?

Dr. LEE. There are limits on balance billing already with the maximum allowable cost (MAAC) program, However, it is very complex system to administer, and we would favor this other approach.

Let me just say one of the reasons why. One, when you go to a new fee schedule you cannot be certain it is correct. As a matter of fact, we are sure we are not going to have it perfect the first time. The ability to balance billing within limits gives you a little insurance. If you underprice certain services, there is some protection to assure patient's access to services.

Mr. PICKLE. Well, do you not think a lot of physicians may interpret the balance billing limit as just a fancy way to get around to mandatory assignment?

Dr. LEE. I think physicians oppose limits on balance billing. I think the great majority do. But the Commission feels that beneficiaries have to be protected, and we feel this is the best way to do it.

Mr. PICKLE. Now, in your report, you have recommended applying a geographic multiplier, I think you call it, to the new Medicare fees. That would attempt to reflect the difference in the cost of practice by areas.

Now, some of my rural doctors tell me that there is no data to show that there is a significant difference in the cost of practice between urban areas and rural areas of any moderate size. Does the Commission have any good data that shows the differences in the cost of practice across geographic areas.

Dr. LEE. Paul, would you address that?

Mr. GINSBURG. Yes. The Urban Institute has been developing an index for HCFA on the cost of practice in different geographic areas. The Commission is using a component of that index to reflect differences in the prices of the overhead costs. Also, the index indicates that costs of practice in rural areas are somewhat lower than in urban areas.

In our simulations, we have used this index from the Urban Institute, and we have found that even though it would result in paying lower fees in rural areas, physicians in rural areas would be paid more than they are today. In fact, in table 3 in our testimony, we indicate that under the Medicare fee schedule in large rural areas—counties with a population of 25,000 or more—physicians on average would be paid 12.8 percent more than under the current system and for the smaller rural areas, the increase would be 15.1 percent.

Mr. PICKLE. Now, what report are you reading from?

Mr. **Ginsburg**. I am reading from our prepared statement for this hearing.

Mr. **Pickle**. Now, in previous hearings, we have asked HCFA if they had proof to show that urban costs were a lot higher than rural costs in the hospital. I do not think we have been given any figures. They just say, well, we think they are higher. Four years ago, 5 years ago, 6 years ago, we thought that. But I do not know that we have any proof.

Now, my rural hospitals tell me that it costs them just as much to keep a rural hospital open as it does in an urban area. I do not know that we have any figures to prove that either one way or the other. What you are reading to me is some new figures' and I do not know where they came from. I want to study them, because I do not want to make the same mistake in the physician fee schedule that we made with the hospitals. And I think this issue has got to be examined very closely.

Now, if you have any figures to show that there should be a difference in the physician fee schedule between rural and urban, I want you to give them to me. I want to know what the source is, because I do not want to make the same mistake. Can you give me some figures?

Mr. **Ginsburg**. Yes, I certainly can give you figures.

I should point out that in hospital payment, Congress made two urban/rural distinctions. First, they did reflect an index of hospital wages in the different areas. But they went one step further and said that there would be an entirely different schedule of DRG payments in rural areas than in urban areas.

That type of distinction is not included in this fee schedule.

Mr. **Pickle**. All right.

Now, Dr. Lee, I see my time is going to run out on me, but you have made a proposal here about expenditure targets. And I know it is important to limit the growth in spending for physician payment. While it is important that we try to control these expenditures—and there is a good reason for it—it seems to me that not all physicians are to be blamed for increasing expenditures.

If doctors were to go over the expenditure target nationwide, how does your Commission propose to protect doctors who deliver primary care? They could be among the ones that could be adversely affected by setting these limits. So it would seem to me like such a proposal would be harsh if you do not balance those concerns. Do you have any plan to balance those?

Dr. **Lee**. Well, I would say the first step is the resource-based relative value scale, which will increase significantly the payments for primary care physicians. This would be particularly true in rural areas where they have been underpaid.

I would agree with you that several factors contribute to increases in volume. One is technology, and there are certain areas where we have seen dramatic increases with great benefit to patients; for example, cataract surgery. Newer approaches to cataract surgery were developed in the early 1980's. Those were put in place by 1984, and there was almost a doubling of the number of patients who had cataract operations between 1984 and 1988. It now appears to be leveling off.

Other new technologies have resulted in significant increases. However, as technologies have become obsolete or as they have become relatively less effective, they have been continued to be used. In many cases it is because the incentives are for physicians to continue to use those technologies. We think that correcting the incentives in the fee schedule will be very helpful.

Mr. PICKLE. Well, Dr. Lee, my time has expired. I must say to you that it is a little difficult for me to understand how you are going to come up with a figure and then how you balance them 1 year or another. That can get awfully complicated, and I think there will need to be a lot more explanation before we can finally understand it. I will try, but I sure do not understand it yet.

Dr. LEE. Well, we will do everything we can, Mr. Pickle, to provide you with information, calculations, and data, particularly on these rural issues, that will be helpful.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you.

Welcome and congratulations. Usually Government moves more slowly than predicted. You may be moving more quickly than predicted. I guess we all want to be sure, including yourselves, that we are moving effectively and in an informed way.

Let me ask you, on the expenditure targets, it is portrayed as something radically different than we now have. But, presently, if we think that costs for Medicare are going to go up too rapidly, we freeze physician reimbursement. Right?

It may be clumsy, but we have had some form of expenditure target or whatever you want to call it in place, have we not?

Dr. LEE. Yes, the MEI. Not updating the MEI is one way of dealing with it. It deals mainly with the price side, and this is an attempt to signal physicians to deal with the volume side. The levers to date have been largely on the price side: freezing prices you pay physicians, not updating the MEI for 6 months, or limiting the MEI update. They have been more on the financing side.

Mr. LEVIN. But you would work more or less the same way by setting an expenditure target and saying to people that if the volume goes up too much, you are going to receive less per procedure, right?

Dr. LEE. Right. But it is more to send a signal, and it is a somewhat different signal than has been sent in the past. It is different when you set an explicit expenditure target and get an agreement on that goal. In the past, you have looked back and said, well, things are going up too rapidly; we will ratchet down here or ratchet down there. In other words, it is an attempt to take a more comprehensive rather than piecemeal approach to the problem.

Mr. GINSBURG. If I could add something to characterize what Mr. Levin is saying, it is that perhaps we have actually been doing expenditure targets but have not had the benefit of signaling in advance that this is what we are doing to get the most constructive response possible.

Mr. LEVIN. So this is really a change from kind of retrospective to prospective targeting. I am not sure exactly how it cuts, but I think it should take some of the rhetoric out of this; you know, as if it is such a radical departure from what is going on. Now, whether it is effective is another issue because it has not worked terribly well retrospectively. Whether it would work any better prospectively, I think is a very legitimate question, and how you would work out these expenditure targets, and whether you should have them nationally or break them down by States.

If physicians in one State are going willy-nilly, why should it penalize physicians in another State, for example?

Dr. LEE. We agree with that and would like to develop a method that would permit that kind of differentiation.

Mr. LEVIN. Now, let us go to another sensitive part of this. We will hear later testimony from the College of Physicians. Let me just read to you one of the critical portions of it on page 10 on the resource-based approach. There are three parts, and I would like your comment on all of them, if you have time. It says that this approach does not take into account the greater diagnostic or therapeutic value of specific services for patients. Second, it ignores the quality of the services provided. Third, it fails to consider other factors that play a major role in determining the value of most other goods and services purchased in our society.

How would you respond to those three critiques of your approach?

Dr. LEE. The quality of care that is provided by a physician cannot really be reflected in a fee schedule. The physician who is recognized as an outstanding physician that provides better quality care is rewarded professionally. They also get a greater volume of patient referrals from other doctors and patients. Let us say the value to a patient for a pair of glasses may be enormous, but glasses are very inexpensive. The caring for a patient who is terminally ill and dying may be more valuable than some very expensive operation in terms of the intrinsic value, yet it does not keep the patient alive.

To reflect the value of different services to patients in a fee schedule, I think, is just about impossible.

On the quality side, again, this has been looked at, and as I mentioned earlier, the measurements of quality are really your own professional standards, the organized professional's standards, and quality assurance programs. We have a variety of mechanisms to assure quality for patients. We have licensure. We have various other mechanisms, including malpractice, an extreme example intervention when patients perceive that quality of care is not adequate.

So I think that the mechanisms are there, but, again, I do not see that you can build those into a fee schedule or a payment system.

I am not quite sure about your last point.

Mr. LEVIN. Well, I think you will have to elaborate. Let me just ask you one quick question as my time runs out. They say that, on the other hand, the reductions for certain services could seriously affect access to some physician services and reduce the interest of many physicians in signing Medicare participation agreements or accepting assignment.

Dr. LEE. I think that is a matter of judgment. We have looked at this and we have done simulations on the impact by specialty. The initial simulations by Hsiao seriously exaggerated the impact by specialty and so led various physician groups to believe that they were going to be much more seriously affected.

We do not believe the extent of the change and particularly the rate of changes caused by the fee schedule will compromise access to care by specialists.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you.

Dr. Lee, this is a revolution, indeed, and I think it certainly moved the debate forward—not one step but many steps at once. In fact, it is so huge a change that I suspect this committee and others will have a while before we totally digest all the implications. Although we have been aware of the Hsiao work, the fact that you bundle this together with so many reinforcing components is very daring and it is revolutionary.

Let me focus on the expenditure targets, because I think that is a crucial component. I gather this is something like the Canadian system. Is that accurate?

Dr. LEE. That is correct. The concept is similar to the Canadian approach, although Canada has a single payer.

Mr. MOODY. Right. Would this not be a single payer—Medicare?

Dr. LEE. It is in Medicare, but in Canada it is for the total population.

Mr. MOODY. Right. But insofar as if the universe is Medicare patients, it is still a single payer.

Dr. LEE. Absolutely, yes.

Mr. MOODY. I recognize that you would like to move from a national to a smaller unit here. It occurs to me that a national expenditure target would present the so-called free rider problem; namely, that it might be advantageous for an individual physician to churn the system—have more patients and increase volume—because the costs of doing so would be spread over such a large universe that he or she would not be singled out for that much attention, unless you buttress this with a lot of utilization review to go along with it. But the smaller the unit, clearly the more the free rider problem is brought back home to the decisionmaker.

You say "Expenditure targets would not alter the financial incentives for individual physicians and their patients." It seems to me that it would or it could very well, in fact, do that. It sounds a little bit naive to say that it would not alter them. Because of the free rider temptation, it seems to me that it would.

Would you want to comment on that?

Dr. LEE. I would like to ask Paul to comment on the free rider question.

Mr. GINSBURG. In a sense, incentives for an individual physician would not be affected because of the free rider effect. They would remain exactly as they are today, in the sense that if a physician is deciding whether to perform a service or not, they know that they will not have any appreciable impact on the expenditure target or on next year's update. I would imagine that barring utilization review or education from the medical profession, physicians would continue to do as they would have in the absence of the target.

Mr. MOODY. So it would alter the incentive. It will not enhance incentives to increase volume.

Mr. Ginsburg. That is right.

Mr. Moody. My question was would there be a serious diminution of incentive to increase volume.

Mr. Ginsburg. No. This policy will not work through incentives. It will work through practice guidelines, utilization review, and broadly changing the political stance of the medical profession towards cost containment options.

Mr. Moody. Right. So this expenditure target, particularly as it starts out as a national universe, has got to be buttressed, for this thing to work, with some pretty intensive utilization review, it seems to me. Am I accurate to say that?

Dr. Lee. Absolutely. It must also include practice guidelines and a more involved medical profession on the volume side of the equation.

Mr. Moody. Yes. You are aware that the latest budget request from HHS actually reduces the amount of money they propose for utilization review activities.

Dr. Lee. Yes. We think that is a big mistake.

Mr. Moody. All right. Well, I have personally raised it with Dr. Sullivan, and it is left exactly in that state. It is raised but not answered. Obviously, in the intermediate range, particularly during all these phase-in periods, there are some serious budgetary implications for your proposal, which I hope our committee will work with you on. But I think it becomes very crucial to do these other things. Otherwise, we might turn out to have the volume go up, and everybody says the thing is a failure. Then we scrap it.

Dr. Lee. You need a integrated approach, one piece is not going to work alone. In other words, just doing one of these things will not be sufficient at all.

Mr. Ginsburg. You are absolutely right. The number of dollars that we spend on administration in Medicare is very tiny compared to what we pay in benefits. If we do not fund that administrative infrastructure adequately for these changes, the program could really fail.

Mr. Moody. Right. Would it be fair to say that your proposal, taken in toto, basically eliminates the current fee-for-service system insofar as it applies to Medicare?

Dr. Lee. It would eliminate the CPR system when the full Medicare fee schedule goes into effect. It would eliminate the present system for physician services.

Mr. Moody. I think that it is clear—for budgetary reasons if no other—that the current system cannot simply be allowed to continue. I think all of us are impressed with the breadth and the boldness of this proposal. While all of us obviously want to study it, I think you are certainly to be commended for this work.

Dr. Lee. The most compelling argument for the Commission in favor of an expenditure target was that the Medicare program cannot continue expenditure increases at the current rate if we as a nation want to cover the uninsured or address other social issues. We have to control medical care expenditure increases, including Medicare expenditures.

Mr. Moody. Right. And volume is always going to be a crucial element there. If we leave the decisionmaking as it is, clearly we will rule out the option of doing some other very important policy goals in our society, like helping the uninsured. The state of health of children in our society has deteriorated sharply. We have to address that, it seems to me. The cost/benefit ratios are so compelling that we cannot ignore the children's health problem that we are now facing, and the list of other things we should be doing, which will all be ruled right off the board if we do not come to grips with the Medicare cost explosion.

I commend you for almost the breathtaking nature of your proposal. Thank you.

Dr. LEE. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I regret that I was unable to hear your initial testimony, Dr. Lee, but I do want to ask a few questions to clarify my thinking.

I do believe that some changes in the way we reimburse physicians are necessary and appropriate. But in your statement you say to limit beneficiary financial liability, it recommends limits on balance billing. I think what you are saying is that we must require physicians to accept the Medicare fee. Is that correct?

Dr. LEE. What we are saying is that for those who do not participate—and we are recommending a continuation of the PAR program with an incentive for participation as exists today—that there should be a limit on balance billing. The limit could, for example, be placed between 115 and 125 percent of the fee schedule amount, because those are limits that Congress has previously adopted.

Mrs. JOHNSON. But to try to simplify this, down what you are trying to do is create a system in which all physicians accept the Medicare fee, and there is no balance billing. Correct?

Dr. LEE. If the fee was at a level that physicians found acceptable, they would not then balance bill patients. But, we do not think that even with the corrections we are proposing that that is going to be the case under all circumstances, and physicians should have the freedom to balance bill in those situations. Therefore, the Commission is not recommending mandatory assignment.

Mrs. JOHNSON. But we would limit the amount they could balance bill?

Dr. LEE. We would limit that.

Mrs. JOHNSON. OK.

Dr. LEE. We would suggest that Congress limit that.

Mrs. JOHNSON. So we are narrowing the amount per patient that any physician could charge. Then on the other side——

Dr. LEE. The MAAC program in use now limits balancing billing. However we think this program should be replaced by across-the-board limits which are much simply than the complex formulations used by the MAAC program to determine limits for each individual physician.

Mrs. JOHNSON. I see. OK. Thank you.

Then your expenditure targets seem to me to function like caps. What is the difference?

Dr. LEE. I would say it is quite different than a cap. If you put a cap on this year, you have to take those costs out or expenditures out this year. If you set a target and you achieve it you get payment in full next year. If you do not achieve the target, the fees get proportionately reduced in the subsequent year. Under a target system, only the increase in the fee is affected. The fees are going to go up year-to-year as practice costs, expenditures, and numbers of beneficiaries go up. So you are not actually reducing expenditures. You are only reducing the rate of increase in the subsequent year.

Mr. **Ginsburg**. If I could add another point of how targets are different from caps, if the rate of increase of volume was lower than the target under this proposal, then the annual physician fee update would be higher than the normal one. Thus, if physicians are successful, their fee increases could go up even faster than they would have in the absence of expenditure targets. So it could work both ways.

Mrs. **Johnson**. So are you, then, providing an incentive to the physician to reduce the number of people they see and the intensity of the care they give?

Dr. **Lee**. The goal is to really reduce the volume of inappropriate or unnecessary services and services of marginal benefit.

Mrs. **Johnson**. OK. Stop right there. I understand the whole problem of inappropriate. Now you are getting into marginal. As I came in, I heard you talking about the Canadian system. They have a much stronger hand on control of marginal-benefit medical services than we do. If you are going to begin to control the provision of services with marginal benefit, how are you going to protect physicians from their liability to have provided all possible appropriate care?

Dr. **Lee**. Well, I think, first of all, the practice guidelines would be one approach to that.

Mrs. **Johnson**. So would you recommend that the practice guidelines have court standing as a state-of-the-art protection against suit for not having provided care beyond the practice guidelines?

Dr. **Lee**. Well, the Commission has not dealt with that issue, so if I give you any comment, it would be a personal comment not a Commission comment.

I think it is a little premature to make that leap, because we have not really seen practice guidelines developed and implemented at the utilization review level. There are already community and national standards that apply in particular malpractice cases.

Mrs. **Johnson**. But they do not have standing and defense in court.

Mr. **Ginsburg**. In the discussions I have had with malpractice attorneys, I understand that a practice guideline developed in a very careful manner by a respected body would have a very good chance of becoming the standard medical protocal for the conditions that the guidelines cover.

Mrs. **Johnson**. I see the red light has gone on for me, and I will respect that. I just bring this up because if we do this in fees, this combination of better controlling balance billing and using targets to constrain reimbursement, as those fee rates and targets sink, as a function of tax policy as opposed to a function of provider care costs, as often happens in the political arena, if you have not paired them with some system whereby you address some of these exposure issues, then you will significantly cripple access to care, in my estimation, of seniors to physician care. And I think we really need to be honest about how these things interface, and I look forward to working with you on it.

Thank you.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

Doctor, I apologize for missing your oral testimony. My plane was late. But I did have an opportunity to look at it prior to your testifying.

If I heard you correctly in response to a question, did you say that you felt that even if we adopted your recommendations in toto that you still feel that physicians are not going to be adequately reimbursed for services provided to Medicare beneficiaries?

Dr. LEE. No, sir. I believe they will be if the fee schedule is adopted as we are recommending it. I think that there will be an appropriate and adequate reimbursement policy.

Mr. DONNELLY. For all procedures?

Dr. LEE. Yes, sir. That is our objective.

Mr. DONNELLY. If that be the case, then, why would you not recommend that we prohibit balance billing? If we are, in fact, reimbursing physicians adequately for services provided, what justification is there then for physicians to charge more than an adequate reimbursement?

Dr. LEE. The problem is that when we initiate this major transformation in the physician payment and create a new fee schedule, we cannot know that we have produced the most effective policies. That is our goal. But if we include the ability to balance bills within limits, then if we have made some errors, there is a little margin to correct them. We can see in balance billing patterns if resource costs for particular kinds of procedures are underestimated and correct them.

Thus, we see balance billing as a form of insurance under a radically different form of physician payment.

Mr. DONNELLY. But it's an insurance that the beneficiary would pay. It seems to me, unless I am missing something, that you are backtracking a little bit on your initial statement that adoption of your recommendations would then provide an adequate reimbursement. Now, you are saying maybe it will not, so we need this failsafe just in case. Is that accurate?

Dr. LEE. That is my view, yes, sir.

Paul, do you have an additional comment?

Mr. DONNELLY. I guess my point is, your recommendations either do or they do not provide adequate reimbursement. And if they do, what is the justification of allowing the beneficiaries to be charged more than what a fair and adequate reimbursement is?

Mr. GINSBURG. I think Dr. Lee might not have been clear. I think as far as the relative payments for the different services, we have confidence that the fee schedule will result in a more rational and appropriate pattern of relative payment. I do not think we know at this point whether in the aggregate, today or 5 years from now, the payment amounts will be adequate, especially for every single physician.

Chairman STARK. Would the gentleman yield? I think the gentleman from Massachusetts should be able to stipulate to that. The issue he makes is done so very eloquently. Suppose you are wrong.

Who then should pay? The beneficiary? Maybe we should take it out of the salaries of the Physician Payment Review Commission.

The point is why stick the poor beneficiary for a mistake that we make here? Why not have the physician come back to the well-equipped Commission, to PhysPRC, and let the physician make his case to you as to why he should have extra money? You who are professionally trained to assess that. Why stick it to the poor beneficiary? That is all we are saying.

We absolutely agree that there could be some entropy in this, something that slips. But why the poor beneficiary? Why should they be stuck with our mistake?

Mr. DONNELLY. If I could take my time back, what you are basically saying is that you are going to hold the physicians harmless to any mistakes made, but you are not going to hold the beneficiaries harmless. I just do not see the justification for that. That on face value to me does not look fair. It seems to me that the burden minimally should be shared equally between the beneficiary and the physician if mistakes are made.

Mr. GINSBURG. I think that might be the case under this proposal to limit balance billing. This proposal is going to cause significant reductions in balance billing for some physicians. So, in a sense, that is a sharing. Also, in our simulations, we see a very substantial reduction in balance billing from the current level under this proposal.

Mr. DONNELLY. I would disagree with that, but I did want to get to just that——

Dr. LEE. Let me just also say why the Commission reached this conclusion on balance billing. In part it was because the past Congress has established it as a precedent. The MAAC program is a limit, in a sense, on balance billing. The radiology fee schedule is also a limit on balance billing.

Mr. DONNELLY. Over my objection. I would have gone farther if I had a chance.

Dr. LEE. I understand that, but you are looking at a Commission which has got a diverse group of people.

Mr. DONNELLY. As does this committee.

Dr. LEE. Right. If we had someone with your persuasive powers on the Commission, we might have decided otherwise.

Mr. DONNELLY. Well, my powers have not been too persuasive on this committee. I do not know how persuasive they would have been on the Commission.

You do make a major recommendation going to a system of mandating balance billing for those at the poverty level. Number 1 what is your justification for that, of just those people at the poverty level? Give me the justification for that first.

Dr. LEE. QMB's are and should be treated as Medicaid beneficiaries and, therefore, have no balance billing. There was a lot of discussion about income or means testing other beneficiaries.

Mr. DONNELLY. In fact, you do, Doctor. This is a means test and an income test for those folks.

Dr. LEE. But that, again, is a policy Congress has already established. Medicare benefits have never been means tested. Medicaid benefits have been. Because QMB's are under Medicaid and title

XIX we felt it would be appropriate that those individuals not be balance billed.

However, we felt as a principle you should not means test beneficiaries in the Medicare program. That was, the consensus of the Commission after considerable discussion.

Mr. DONNELLY. But you are means testing it at a certain point, and the basis of that decision was based on action that, in fact, this committee took.

Dr. LEE. Correct.

Mr. DONNELLY. Well, I hate to see you base some of your activities and decisions on actions that we might take. My time is expired. Thank you very much, Doctor. Thank you, Mr. Ginsburg.

Are there any additional questions? Mrs. Johnson.

Mrs. JOHNSON. While we have these witnesses here, I think that it is important to try to get a little bit more clearly to the issue of how this target functions as a cap, and what is the relationship between that cap and access to service, both in terms of numbers of patients and a variety of intensity of care given. Because when you make the analogy to other nations, all other nations have a means of regulating those things. And to say that practice guidances will regulate them, when those are not in place and we do not know how they will work, seems to me inadequate.

If you are going to have a target, what is the difference between target and price control? Even though I see what you are saying about it is a little more flexible. If we say we are going to spend *x* amount of money on reimbursing physicians in America, regardless of how we fiddle around with exactly how we are going to implement that system, I do not see the difference between that and Congress saying—which we have said for years—we are going to spend *x* amount of money on the VA system. And I will tell you, it has compromised access in that system, and it has compromised quality. And over a long period, when you stretch this out after the first year or the second year or the third year, or 5 years, it seems to me that you are going to get this target, flexible as it is and complex and all that stuff, ultimately that capping of how much we are going to spend on physician reimbursement. Presumably, we are doing it to get a downward trend in that line.

So as that downward trend in the line is pressed up against by a larger number of Medicare recipients living in a more complex medical environment and, therefore, we are having access to more complex and high cost intervention, how are you going to make that line decline and not compromise intensity of care?

Dr. LEE. Well, I think there are several things that led the Commission to make the decision with respect to targets. The most important was the rate of increase in part B expenditures, which has been 17 percent a year for the last decade now, half of that due to increase in volume. It cannot be sustained. We do not have the resources in this country to continue to increase part B expenditures 17 percent a year.

Mrs. JOHNSON. Wait right there, Dr. Lee. If half of the increase is due to volume, and if in the future half of the increase is due to volume, I mean, does that not make my point?

Dr. LEE. There has to be some way to slow this rate of increase. A second reason was that we had been given ample testimony that in a variety of areas there is a significant amount of inappropriate and unnecessary care being provided. If the medical profession dealing on a peer level could eliminate those unnecessary services, you would have ample resources not only for part B, but to do other things as well.

It has been estimated that between 20 to 30 percent of medical care is unnecessary or of marginal benefit to the patient.

Mrs. JOHNSON. Wait a minute. If 10 percent represents unnecessary care or even 30 percent, but 50 percent is volume increases, I do think those figures support my point; that in the long run, this is going to have to indicate that somehow fewer people are going to have to be seen or fewer times.

Dr. LEE. You have a greater intensity of service. In the data we have from our beneficiary survey, less than one-half of 1 percent of beneficiaries were refused care for financial reasons and less than 5 percent deferred care for economic reasons. So it is not so much a problem of access, as what happens once the person accesses the system. There is a volume intensity of services, and there is a certain percentage of those services that are inappropriate, unnecessary and, in some cases, harmful. I could cite many examples.

So if you can control volume increases through effective management of use of service, you could make very substantial savings over time.

Mrs. JOHNSON. OK. I will sit down with you at some other time about this, because I absolutely agree with you that we have to eliminate the inappropriate care, and that that will reduce the costs of the system. But to do it by capping outlays, which is ultimately what this is going to do, is going to cause us to limit care in exactly the same way that the VA system has experienced limits of care, that Medicaid has experienced limits of care. And I think the fundamental approach of capping outlays, especially when half of the increase in your outlays is driven by increases in volume, is questionable. And I am concerned that you are looking only at the inappropriate care component and what that is doing to costs, because there are several other components that are definitely driving costs, that if we eliminate them would not affect either access or quality.

Dr. LEE. What you are doing is slowing the rate of increase. You are not, in fact, capping. VA is a budgeted program. You cap it. It is very different than what has happened with the VA, I think.

Mrs. JOHNSON. I believe it is going to become the same, though. That is my point.

Mr. DONNELLY. Thank you.

Mr. Moody.

Mr. MOODY. Just briefly, I would like to just jump in for 1 second here. I think the VA is very different. It is an appropriated program. It is not an entitlement. VA is probably one of the most inefficient programs in Government. The reason the access has been harmed, in my judgment, at least, from my observation, is not because of these budgetary restraints. The budgetary restraints have harmed access only if you are willing to permit the continued level of gross inefficiency that exists. If you are willing to reorganized VA to get to inefficiencies, access would not be harmed. But reorganization will never occur without some budgetary restraint.

Mr. **Donnelly**. Thank you. Maybe we can continue this discussion a little bit later. The full committee has a luncheon at 12:30 with the chairman, so we are going to try to have all of the testimony completed prior to that time.

Thank you very much, Dr. Lee and Mr. Ginsburg. We appreciate your testimony, and we look forward to working with you.

Mr. **Donnelly**. Our next witness is from the American Association of Retired Persons, Mr. Frank Delay. He is a member of the board of directors from Mesa, Arizona. Please proceed.

STATEMENT OF FRANK DELAY, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP), ACCOMPANIED BY STEPHANIE KENNAN, FEDERAL AFFAIRS STAFF

Mr. **Delay**. Thank you, Mr. Chairman. I am Frank Delay, a member of the board of directors of the American Association of Retired Persons. I am accompanied by Stephanie Kennan of our Federal affairs staff.

We appreciate the opportunity to present our views on physician payment reform. We particularly appreciate the opportunity to present our views immediately following the Physician Payment Review Commission. My written statement expresses in detail our reaction to the Commission's report. I will outline a few points today.

First, we begin with the premise that the purpose of Medicare is to provide beneficiaries with financial protection for access to needed health services. Payments to physician is our means of achieving that objective.

Second, AARP continues to support a resource-based relative value scale. However, it is critical to remember that any change in payment rates, even if budget neutral in the aggregate, means beneficiaries will be affected differently. Simply put, I do not visit my doctor in the aggregate. I have specific medical needs and visit specific doctors. I will need to know how changes in payments affect me.

For example, raising payments for primary care services may encourage doctors to perform more primary care. But my coinsurance will rise. How will this impact my access to care?

Third, AARP recognizes that volume is a key issue. While some state that beneficiaries are responsible for this increase in volume, I would like to state that the doctor, not the patient, is the decisionmaker concerning what services will be performed. The number of office visits per beneficiary have remained stable over the past decade. Out-of-pocket costs of part B services paid by the beneficiary in the form of premiums and coinsurance is increasing, in part because of the increase in the volume of services. The part B premium has risen 91 percent since 1984. Coinsurance is now over $7 billion, having increased from just over $2 billion in 1981. The impact on the beneficiary must be understood before reforms are adopted.

I would like to interject at this point that the association does not support the Bush administration's proposal to extend the requirement that premiums equal 25 percent of program costs. Beneficiaries can no longer afford to continue paying 25 percent of a cost over which they have no control.

Again, concerning volume, AARP strongly supports the PhysPRC recommendations for further research and the development of practice guidelines as one method to control volume. Determining what is effective care is essential before moving forward to other steps to control volume.

Another approach favored by the PhysPRC is a national expenditure target. AARP approaches the concept of expenditure targets cautiously. The concept of a national target as proposed by PhysPRC is a useful one. However, AARP has many questions, such as: How will the target be implemented? Who will set it? And will it create cost-shifting to the non-Medicare purchases of health care?

From the beneficiary perspective, volume must be controlled, and beneficiaries will want to be a part of further discussions about expenditure targets.

Fourth, we support PhysPRC recommendations concerning monitoring access to care and the impact on beneficiaries. This is crucial to any reformed system. This information will be vital in refining the payment system over time and in assuring that we meet our goals of providing financial protection and access to care.

Fifth, PhysPRC recommends a transition period of 2 years. We believe that any change in payment systems should be implemented over a transition period of at least 5 years to avoid abrupt changes for providers and patients.

Sixth, it is important that we have beneficiary protections to prevent cost-shifting to beneficiaries. We strongly support the continuation of the PAR program and balance billing limits as PhysPRC recommends, but we view these as transition steps towards mandatory assignment. Once fair and rational fees are achieved, why should a physician be permitted to balance bill any patient for what is above and beyond the fair fee, as you mentioned, sir?

Mr. DONNELLY. We are going to get you elected to Congress, Frank. [Laughter.]

Mr. DELAY. We applaud the Commission for recommending that physicians be required to file patients' claim forms with Medicare. This step is important in streamlining the system for beneficiaries and assuring that they receive benefits they are entitled to.

Finally, Mr. Chairman, we realize that the pressures to reducing the budget deficit will continue in the years to come. While budget considerations are not part of PhysPRC's mandate, we urge you to keep this pressure in mind as you design a new payment system. The new system must be able to withstand attempts to achieve budget savings without harming the integrity of the system.

I thank you.

[The statement of Mr. Delay follows:]

Before the Subcommittee on Health
of the House Committee on Ways and Means

March 21, 1989

Mr. Chairman, and members of the Subcommittee, I am Frank Delay, a member of the Board of Directors of the American Association of Retired Persons (AARP).

We appreciate this opportunity to appear before the Subcommittee to present our views on physician payment reform.

The Association continues to support the goal of revising Medicare's physician payment methodology through the use of a fee schedule based on a resource based relative value schedule. We have had the opportunity to review a number of physician payment issues from the beneficiary perspective with the Physician Payment Review Commission (PPRC), in hearings and in meetings with their staff.

Our testimony today covers several areas: 1) problems with the existing payment system; 2) recent actions in physician payment reform, and the beneficiary community's interest in controlling the growth in Part B expenditures; 3) AARP's perspective on payment reforms, the fee schedule revisions suggested by the PPRC, and the need for a better understanding of the impact of payment proposals on beneficiaries; 4) other important elements of the PPRC plan -- elements that are necessary to any payment reform plan -- such as beneficiary protections and volume controls; 5) the American College of Surgeons' proposal; and, 6) a summary of what AARP sees as the key elements which need to be incorporated in any physician payment reform initiative.

Background

Physician payment reform has generated a complicated, technical debate among government policy and budget officials, researchers, and physician specialty and subspecialty associations. That debate is vitally important, but we think it useful to go back to the basics when assessing issues as complicated as physician payment reform.

AARP approaches this issue with what we hope is not a novel premise -- that Medicare exists to assure financial access to health care for the 33 million elderly and disabled individuals insured under the program. Medicare has brought to its beneficiaries access to care generally comparable to the rest of the population and provided financial protection for the cost of covered services. But rapidly rising costs are eroding that protection.

For me and for 33 million other Americans -- and for the rest of the population as they age -- Medicare is not a technical policy issue -- it is our health insurance plan. It was enacted because the nation recognized that a Federal social insurance program -- Medicare -- was appropriate and necessary to support health benefits coverage for the aged and disabled, with Medicaid providing means tested coverage for the poor. The reason was, and remains, that the traditional vehicles for support of health benefits are less available to the elderly. For example, federal tax incentives provide substantial governmental support for the many younger, working individuals in employer-based group health insurance -- at a cost estimated at about $30 billion in tax expenditures in FY 1990. That support and numerous other advantages of group health benefits are less available to elderly persons.

Problems with Existing Payment System

AARP believes that there are five fundamental problems with the existing payment system that must be addressed:

- The payment system has been inherently inflationary since its inception in that payment levels rise with the increase in billed charges (subject to some constraints);
- The fee-for-service methodology encourages the provision of an increasing volume of visits and tests;
- The payment methodology reflects -- and contributes to -- numerous distortions in the medical care market -- often based on the charging patterns existing in the early 1970s. These distortions account for unjustifiable differences in fees among different types of services, and among different locations.
- The system does not provide adequate financial protection to beneficiaries against charges over and above what Medicare determines to be reasonable; despite recent improvements in this regard, physicians still have the option to extra-bill the beneficiary after Medicare has decided on the charge which it determines to be reasonable.
- Finally, the system is enormously complicated for beneficiaries, physicians, and the government to understand and to deal with. Could any member of the Subcommittee give a complete description of the determination of the reasonable charge, the PAR/non-PAR program, assignment, computation of the MAAC limits, and procedures for filing bills and getting them paid? Yet every day, beneficiaries and physicians have to try to wend their way through that very system.

Recent Actions, and Beneficiary Interest in Controlling Expenditure Growth

Over the past few years, the Congress has addressed a number of these issues. The creation of the Physician Payment Review Commission was an effort to begin working toward long-range reform of the system. In addition, shorter-term legislative actions have been taken as well. Congress has imposed a number of constraints on physician payments -- and has always accompanied those constraints with beneficiary protections. Those protections are particularly important because they help assure that the federal savings in payments for physicians' services are not shifted to the beneficiary in the form of increased extra-billing. The participating physician (PAR) program and the maximum allowable actual charge (MAAC) limits have helped to increase the assignment rate. Equally important, they provide a framework that, with enhancements, can help protect the beneficiary from having payment reductions passed on to us under any future payment reforms. Let me state clearly that in any further reform of the system, beneficiaries should share in any savings achieved.

The PPRC's March, 1988 report provides a useful graph, which I have attached to my testimony, which highlights the fact that the beneficiary protection initiatives (PARs and MAACs) have slowed the growth in extra-billings -- which until recently had been the fastest growing portion of out-of-pocket payments by beneficiaries under Part B. Given continuing and enhanced financial protections against extra-billings, the most serious financial problem that beneficiaries now face in Part B of Medicare is that overall spending continues to grow too fast.

This is an important issue for beneficiaries because we share substantially in the cost of that spending growth through Part B premiums, deductibles, coinsurance, and taxes.

For example, annual Part B premiums have increased 91 percent since 1984 -- from $175.20 to $334.80, exclusive of the monthly catastrophic coverage premium that all Part B enrollees will pay.

AARP believes that any physician payment reform, assuming protections against extra-billing, must be more than simply adjusting payment levels to create greater equity among physicians. Reform must also address rapid expenditure growth under Part B of Medicare. In fiscal year 1988, beneficiaries paid $1.8 billion for the Part B deductible, and $7.14 billion in coinsurance. As a beneficiary who pays for a substantial portion of Part B payments through my premium, deductibles, coinsurance, and taxes, I want to be sure that overall spending controls are included.

Further, as the Subcommittee is only too well aware, the pressures to achieve savings in Medicare will continue into the forseeable future. Whatever new system you devise must not only provide a far more rational system, but also be able to accomodate future federal budget pressures without harming the integrity of the program.

AARP Views on Payment Reform

As I noted earlier, AARP continues to support reform in Medicare's physician payment methods in order to enhance the ability of Medicare to provide financial access to health services, and financial protection for beneficiaries for the cost of those services. The initial phase of the debate on physician payment reform has focused on adjusting payment levels among types of physicians' services and the geographic areas in which those services are provided. That is, of course, an important policy and technical issue, and one of great interest to the various segments of the physician community. The debate on how best to implement Medicare's fundamental purpose -- the protection of beneficiaries and the assurance of continued access to affordable care -- has just begun.

RVS Revisions, Practice Costs, and Geographic Multipliers

A great deal of work has been done by PPRC and others to quantify, assess, and revise payment schedules for physician services. The original Resource Based Relative Value Schedule (RBRVS) developed at Harvard has been subject to a great deal of debate, and the PPRC has developed substantial modifications in the Harvard methodology. These include revisions in the method of determining overhead and practice costs, elimination of specialty differentials, and the use of global fees.

AARP concurs with PPRC's recommendation that a practice cost index reflect only overhead costs. We are concerned, however, that the potential impact of a geographic multiplier on beneficiaries' cost-sharing has not been carefully analyzed. In principal, since Medicare is a national health insurance program, beneficiaries should be provided equal financial protections and burdens for similar services wherever they reside. The precise means by which legitimate variations in cost should be included requires further work. It is reasonable to assume that some type of geographic adjustment is necessary to account for differences in costs such as rent and labor.

While the impact of some of these changes remains unclear, the Commission's continuing efforts and future plans to revise the fee schedule methodology will be important if the Congress chooses to make use of the RBRVS approach in enacting physician payment reform.

Impact on Beneficiaries

While most of the debate and technical revisions have centered on issues concerning the physician community, AARP believes that it is equally important to recognize and assess the beneficiary impact of the relative value scale as well as other reform possibilities before you proceed.

The beneficiary impact of revising the fee schedule arises because a fee schedule changes the payment rates, and therefore the coinsurance rates. Thus, when you hear about payments for certain procedures or services, or in certain areas, being raised or lowered by 10 percent or 20 percent, you should recognize that you are making similar changes in coinsurance.

This concern about the coinsurance effects of fee schedule changes may appear to be self-evident, but it must be assessed carefully, because the payment changes create provider and beneficiary incentives which conflict. If you raise the amount I have to pay in coinsurance for primary care services, making those services more costly for me to receive, you tend to impose an increased financial barrier to my seeking care. Yet a major thrust of the RBRVS seems to be to encourage the provision of that same primary care service by increasing the provider's payment for primary care. The physician may be more likely to provide the service, but the patient is exposed to a greater financial barrier to that same service, which may make them less likely to seek the care. This is an important issue since primary care is typically the entry point to the medical system. This could impose the greatest problems for chronically ill persons who need frequent physician visits. Comparable problems arise as payments increase and decrease in specific geographic areas. For example, if payments in certain rural areas are increased, as they would be under the PPRC approach, coinsurance for individuals in those areas increases as well, again creating potentially conflicting physician and patient responses.

Extra-billing and assignment implications also need to be understood and assessed carefully. Increases in payment rates may make it less likely in the short-term that some physicians would extra-bill, while decreases would appear to make it more likely that others would extra bill. Thus, these effects could offset some of the coinsurance effects, but it is not at all certain. For the elderly beneficiary whose coinsurance for a service is definitely increasing, a potential decrease in extra-billing is small solace. AARP believes that specific constraints on extra-billing must be included to make sure that beneficiaries benefit through reduced extra-billing when payment rates (and coinsurance) increase, and do not have fee reductions shifted to them in the form of increased extra-billings.

In our testimony to the PPRC and our discussions with them, AARP has asked that the Commission develop beneficiary analyses as part of their review, for two reasons. First, we want to be sure that the Commission itself assesses beneficiary impact as part of its deliberations, much as it must of necessity consider the impact of various proposals on various specialties of physicians. Second, the beneficiary analyses can provide information for the Congress and others that is useful in making assessments and decisions about payment reform.

Beneficiary Simulation

The PPRC has developed a beneficiary simulation which will be included in their report to the Congress.

At this point, AARP appreciates the fact that the PPRC has made progress in assessing the beneficiary impact, but much of the analysis remains at relatively large "aggregate" levels. We need to look more precisely at the impact of specific payment changes on beneficiaries. Patients do not visit a physician in the "aggregate." I encounter specific medical problems and need to see specific doctors. What will be the impact on me and my neighbors, whose need for care may be quite different? For example, how will coinsurance and extra-billing, change for an 80 year old woman living in a rural area who needs primary care services? What about a beneficiary living in an urban area, who requires surgical services?

Most of the PPRC models assume no change in billing or participation, assignment, volume and access. However, much of the underlying rationale for developing a revised payment system appears to be based on the assumption -- and goal -- that we want to change some of these behaviors. The change in payments now envisioned would appear to be based on an implicit assumption that fee increases will increase use and access to evaluation and management services, and to services in certain geographic areas, such as rural areas.

While, on average, beneficiaries will fare as well under the proposal as they do today, the reality is that some will do better and some worse, and AARP has recently asked the Commission to assess more precisely these effects. How many would be better off, and how many worse off? What are the characteristics of the "winners" and "losers" -- for example, beneficiaries who are subject to higher or lower coinsurance as a result of the payment schedule changes, or beneficiaries whose access might be changed?

The Commission, AARP, and the Congress need to understand the characteristics of those beneficiaries who will see their cost-sharing increase or decrease because of reform proposals, and determine if provisions should be incorporated into the plan to minimize those effects. We urge the Subcommittee not to act until the Congress has a clear understanding of the implications for beneficiaries most affected by the plan. Further, we urge the Congress to implement any reform on a gradual, phased basis over a period of up to 5 years, in order to minimize abrupt changes in payments for either beneficiaries or providers.

Revised fee schedules such as those developed by the PPRC have unknown but vitally important implications for the volume of services provided by physicians, beneficiary access to specific types of services in specific geographic areas, and quality. Like extra-billing, the potential implications and physician responses are the subject of much speculation, but difficult to test empirically.

While it may not be important that we agree on simulation models which project what might happen in areas such as volume, access, and even extra billing, the policy process should be able to identify what we want to have happen -- for those are presumably among the reasons that the payment rates are being changed. It would appear to us to be valuable to state explicitly certain goals in these areas -- such as goals for increased volume and access for certain services, and in certain areas, and increased assignment rates or decreased extra billing amounts. No new system can guarantee achievement of all its goals immediately. Monitoring will be necessary to determine if the goals and assumptions on which the new system is based are in fact being met, and, if not, what further policy changes might be necessary.

We were pleased to see that the PPRC included a monitoring strategy in their recommendations. We urge the Congress to include and appropriately fund such a monitoring initiative as part of any payment reform that you develop. And, we ask that you go even farther, and set and define explicitly the goals and assumptions about volume, access and use, and beneficiary financial protection on which you are basing the revised system, and then use the monitoring system to assess whether those goals are being met.

Beneficiary Financial Protections

AARP believes strongly that one objective of physician payment reform should be the creation of fair and rational fees. Once fair fees are achieved, extra-billing should no longer be permitted. AARP views balance billing limits and the continuation of the Participating Physician (PAR) program as transition steps to mandatory assignment.

The PPRC recommendations include some steps to provide financial protection for beneficiaries from the cost of extra-billing. AARP is generally supportive of the PPRC recommendations to set some upper limit on the amount of extra-billing on unassigned claims, so long as those limits enhance the financial protection afforded by the current MAAC limits. In addition, the AARP supports the PPRC recommendation to maintain the PAR program.

Qualified Medicare Beneficiaries

We are very concerned about the PPRC recommendation for limiting mandatory assignment for "Qualified Medicare Beneficiaries" (QMBs). These are individuals with income below the federal poverty level identified under the recently enacted Medicare catastrophic coverage act. State Medicaid programs have to "buy" such individuals into Medicare coverage by paying their premiums, deductibles, and copayments, but do not have to provide Medicaid coverage for them.

As you know, Mr. Chairman, AARP has long opposed any effort to means- or income-test benefits under the Medicare program. Medicare has achieved a quarter century of success as a social insurance program for the elderly and disabled, with Medicaid the appropriate vehicle for means-tested health benefits.

AARP believes that any effort to means-test Medicare benefits would lead to the undermining of the social insurance foundation on which the program is built. Administratively, means-testing would be a nightmare, if not impossible. It is our understanding that when the Congress provided for the Medicare buy-in for the qualified Medicare beneficiaries, you did not consider them as eligible for Medicaid benefits, but rather as Medicare beneficiaries.. AARP would certainly support enhancements to Medicaid, but opposes any move to open the door to means testing benefits under Medicare.

Assignment when the beneficiary has no choice of providers

Another assignment proposal by the Commission appears to be more promising. PPRC has proposed mandatory assignment for services for which the beneficiary has no choice of provider. While the specifics of such a proposal need to be developed, it is a concept that AARP would be able to endorse. We would include hospital-based physicians' services, as well as other situations in which there is no choice of practitioner.

Claims Forms

Finally, we were very pleased to see that the PPRC included a recommendation that physicians submit claims for all beneficiaries directly to Medicare, which would greatly facilitate the administrative process for beneficiaries. We believe physicians should not be permitted to charge for filing claim forms, and that these PPRC recommendations are necessary steps for streamlining the program for beneficiaries.

It is important to note again that we believe that all of these beneficiary protection initiatives should be viewed in the context of our longer range goals in this area.

Volume Issues

AARP recognizes that a fee schedule alone will not address the continuing increases we see in the volume of Part B services. As I noted earlier, little is known about the impact of a revised fee schedule on volume.

Practice Guidelines

One constructive step to address volume issues was outlined by the PPRC in their recommendation for enhanced research on medical outcomes and development and dissemination of practice guidelines. Such an approach can help assure that physician payment reform leads to longer-term redirection of medical services to the more effective modes of treatment. We support enhanced investments in these efforts as a means of stimulating the longer-range reforms desired.

Expenditure Targets

A second approach to dealing with volume is through expenditure targets, and the PPRC has recommended moving to a national target based on volume of services per beneficiary.

While the framework of PPRC's proposal may be supportable and is certainly a more useful approach than other options studied by the commission, AARP has several fundamental questions about the implementation and impact of targets on our overall health care system.

- First, numerous questions arise about implementation of the concept. How are the targets computed, set, enforced, and responded to by the physician community? How would physicians in a community or a specialty assess their progress toward a volume target? What decisions might they make if volume is too high, or too low, compared with the target? How do they arrive at these decisions? Equally important, how does the individual physician respond? How do targeted volume reductions apply to an individual physician providing services to an individual patient?

- Second, it is vitally important to understand the implications of any reductions in access to services which might arise in response to a target. Volume reductions mean that visits, procedures, or tests are not performed. What specific services, in what areas, and for which patients, are reduced to meet a target?

- Third, what role will beneficiaries have in the setting, implementation, and response to a target. From the beneficiary perspective, if Medicare spending in my community is subject to some limits, I want to be represented in decisions about how the community will respond to those limits. Even with the best of intentions, the way the government and physician community may wish to respond to the targets may not be in the beneficiaries short- or long-term interests.

- Fourth, what will be the impact of expenditure targets on the overall health care system. Other countries which have such targets have national health insurance systems, while in this country we have multiple purchasers of care. How would Medicare expenditure targets effect the cost and access to care of the Medicare population and non-Medicare population? Would savings be shifted to the non-Medicare population, raising the price of their care? Such cost shifts would raise the cost of employee health benefits. As this Committee knows, the tax treatment of such benefit costs means that the cost-shift would result in increased tax expenditures for such benefits.

In the area of expenditure targets, as well as other elements of any reform plan, substantial transition periods as long as 5 years may be required to provide for informed implementation and to avoid abrubt changes.

American College of Surgeons Plan

In addition to the PPRC proposal and variants of a resource based relative value scale, the Subcommittee is reviewing an alternative proposal which has been suggested by the American College of Surgeons (ACS). While AARP appreciates that fact that ACS has recognized the need for some moderation in the rate of increase in Medicare spending for physician services, we have a number of concerns with their plan.

AARP believes that any physician payment reform proposal should address all physician services -- not be limited to specific specialties. Reform may apply different rules and standards to different services, but should be comprehensive in its approach. Thus, whether you decide on the PPRC proposal, the ACS approach, or some option to be developed, we urge you to apply payment reforms to all physicians services.

To address some of the specifics of the ACS proposal, AARP must first state our firm opposition to the ACS proposal to means-test assignment policy. As I noted earlier, AARP would support Medicaid expansions as the appropriate means for enhancing benefits for the low-income elderly and disabled, but will adamantly oppose any effort to means-test Medicare benefits, because means-testing undermines the foundation of social insurance on which the Medicare progam and Social Security Security are based.

The second assignment-related provision in the ACS proposal is mandatory assignment for surgical services when the beneficiary has no choice of providers. AARP regards this as a more promising initiative once the specifics are developed. In addition, we appreciate the fact that the surgical community is not advocating the concept of an "indemnity" fee schedule which is traditionally advocated by the physician community. As you know, Mr. Chairman, an "indemnity" schedule is the technical description used by the physician community to describe a fee schedule under which Medicare sets the fees but the physician is free to extra-bill the beneficiary whatever he or she can get away with.

AARP is also unsure about the effect of the ACS proposal to blend "demand" side factors with resource price factors in determining the relative value schedule. It is unclear to us how those factors would be defined and quantified.

Finally, we view the ACS volume initiatives in much the same way that we discussed for the PPRC proposal. We support the idea of developing practice guidelines, but are unsure how expenditure targets would be implemented. The ACS expenditure target proposal does, however, raise two policy issues that the Congress needs to consider carefully. First, if expenditure targets are to move beyond the national level, is it most appropriate to establish them at the specialty level (as suggested by ACS) or at a geographic level (as suggested by PPRC)? Second, if expenditure targets are to be established, is the type of phasing schedule advocated by ACS appropriate, with development of data and targets first, and the targets phased into the payment system in later years?

Conclusion

AARP continues to support the goals of physician payment reform, and ask you to consider seven key points as you develop your proposals.

First, we begin with the premise that the purpose of Medicare is to provide beneficiaries financial protection for access to needed health services. Payments to physicians are a means for achieving that objective. The Congress must evaluate its proposals against that objective.

Second, any change in payment rates such as those arising from an RBRVS, even if budget neutral in the aggregate, means that some beneficiaries would pay more in coinsurance for some important services or in some places -- generally the very services an RBRVS proposes to encourage -- and less for others. The Congress cannot ignore the fact that while a payment reform proposal may be budget neutral in the aggregate it will not likely be budget neutral for the individual beneficiary. Further information on the distribution and characteristics of the "winners" and "losers" is essential before action is taken.

Third, AARP recognizes volume as a key issue. However, no clear cut solution appears on the horizon. The Association believes it is necessary to pursue continuing research and development of practice guidelines. These guidelines, once established, should be incorporated into the payment system before expenditure targets are considered further. PPRC proposals for a national expenditure target requires greater elaboration but holds promise.

Fourth, monitoring volume, access to care and impact on beneficiaries is crucial to any reformed system, and might best be preceeded by explicit statements of Congressional goals in these areas. This information will be vital to see if the system achives the results intended, and to provide information that would be useful to refine the payment system over time.

Fifth, any changes in the payment system should be implemented in phases over a transition period of five or more years. That is important to minimize problems arising from sharp changes in beneficiary payments and providers fees. In addition, it would provide time to evaluate the impact of the initial changes and refine the system as we proceed.

Sixth, the major out-of-pocket spending increases by beneficiaries now arise from the beneficiaries' significant contribution for deductibles, coinsurance, and premiums -- increases which stem directly from the escalating cost of Part B of Medicare. Assuming continuing and enhanced protections from extra billing we would want payment reform to provide a vehicle for reduction in the rate of increase in both government and beneficiary spending.

Finally we would urge the Congress to maintain the policy of assuring that payment changes be accompanied by beneficiary financial protection from extra billings. This includes mandatory assignment once fair fees are achieved through reform.

AARP thanks the Subcommittee for this opportunity to appear today to discuss this important issue, and I would be pleased to answer any questions that you may have.

Mr. Donnelly. Thank you very much.

Mr. Levin.

Mr. Levin. We welcome your testimony. I just wanted to make a comment on the expenditure targets. We discussed this earlier. I think most, if not all, of us share your caution, but we should remember that under the present system as we discussed earlier, we have a form of them right now. We may do it after the fact, and then this committee is charged with finding $2, $3, $4 billion, in a sense because the money has been spent already. So while you are very cautious, I hope that your very large and important organization will not be too cautious.

We need to find a system that has more rationality than the present one of scrambling around trying to find $2, $3, $4 billion. And if expenditure cuts have their problems—and they surely have their questions—I think we will welcome your thoughts about what else we do.

Thank you very much, Mr. Chairman.

Mr. Donnelly. Mr. Moody.

Mr. Moody. Thank you.

You said in passing that you do not support the return to what used to be standard policy of having the beneficiaries pay one-quarter of the cost under part B. Who do you recommend pay it? Since someone else already pays three-quarters, who do you recommend pay that final quarter?

Mr. DeLay. We feel that it is unjust to ask somebody to pay something that he has no control over.

Mr. Moody. Well, then, who does have control over it?

Mr. DeLay. Well, we are hoping that the action of this committee and Congress will find means of decreasing the rate of increase so that it will not go up at three or four times the cost of living, as it has in the past.

Mr. Moody. So are we all hoping that. Our efforts, hopefully, will bear fruit. But insofar as whatever those costs end up being after we have worked our will, hopefully to bring them under control, in the end there will be some increases in cost. There is no way to zero them out, but restraining the growth. The growth having been restrained, is it not only fair to ask the beneficiaries to pay one-quarter of that rather than asking others in the society?

Mr. DeLay. I think that we would hope that we find some means of, as I say, reducing the rate of costs so that it is reasonable that the beneficiary does not continue to pay a very sharply increased amount. It is my understanding, Mr. Moody, that the elderly now pay more for medical care than they did before Medicare was instituted. And this is the problem of the beneficiary facing an ever-increasing cost.

Mr. Moody. Right, and we all want to bring it down. But at the end of the day when the costs have been restrained insofar as they can be, then there is the question of who bears what portion of what has to be paid.

Any dollar we take out of general revenues for health care that is not borne by that beneficiary is a dollar less that we have to spend on other forms of health care. And as you know, there are crying national needs of the uninsured. We are the only industrialized society that does not cover its children. And every dollar you insist that you not pay, even though it is only 25 percent, is a dollar we are not going to have for other very urgent health needs.

Now, I would hope the AARP would not take the point of view that they do not want to share at least a quarter of only part B. That seems to me a very selfish point of view if it is sustained. I just do not see it.

We are all working to keep the costs down, but when the costs are restrained, whenever they are, this historic norm it seems to me is very generous towards senior citizens for three-quarters of a program they pay nothing into. Part B was not part of their withholding when they were working. Three-quarters is a very generous cost-sharing. It seems to me that we should not try to change that. I think that would set up a reaction in the rest of society that would, in the end, be harmful to senior citizens.

I would hope you would reconsider that particular part of your testimony.

Mr. DELAY. Thank you.

Mr. DONNELLY. Mr. Delay, at the outset, the committee wants to thank you and your organization for the strong support you provided last year when we were drafting the catastrophic legislation. Are you still with us?

Mr. DELAY. Yes.

Mr. DONNELLY. OK. Hang in there, Frank.

I have two questions, one on the whole issue of balance billing and the other on the so-called 25 percent rule. If I heard you correctly, what you are saying is that the position of AARP at this point in time is that you favor, as a transition, this prohibition of billing to those at the poverty level and below, but you would like to see us go to a system where balance billing is prohibited totally. Is that correct?

Mr. DELAY. Eventually, we would like to see balance billing eliminated, yes. We would like to see mandatory assignment eventually.

Mr. DONNELLY. But at this point in time, you are endorsing the proposal by the Commission?

Mr. DELAY. That is right.

Mr. DONNELLY. But you do agree with me, to the extent that if, in fact, we do create a system of reimbursement that adequately reimburses physicians for services, then that ought to be it; that, in fact, the physicians receive a fair set fee, so there ought not to be any extra fees added on over and above that, which would mean the adoption of some sort of mandatory assignment and an end to so-called balance billing?

Mr. DELAY. I think you state our position beautifully.

[The following was subsequently received:]

AMERICAN ASSOCIATION OF RETIRED PERSONS,
Washington, D.C., April 5, 1989.

Hon. FORTNEY STARK,
Chairman, Ways and Means, Subcommittee on Health, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is to clarify our answer in response to a question concerning the recommendations of the Physician Payment Review Commission at the subcommittee's hearings on March 21.

Mr. Donnelly asked Mr. Delay if AARP supported all of the Commission's recommendations concerning balance billing, including eliminating balance billing for Qualified Medicare Beneficiaries.

Mr. Delay responded that the Association did support these steps as transition steps to mandatory assignment. AARP is concerned that this response may be interpreted to mean we support means-testing as a transition step. The Association does not support means-testing. Confusion exists because some have interpreted "QMB's" to be Medicaid beneficiaries and others interpret this class to be Medicare beneficiaries for whom Medicaid pays cost-sharing requirements. If QMBs are Medicaid beneficiaries, we believe all classes of Medicaid beneficiaries should receive protection from balancing billing.

We would appreciate this clarification being inserted into the hearing record.

Thank you for your consideration of this matter.

Sincerely,

John Rother,
Director, Legislation Research and Public Policy.

Mr. Donnelly. Thank you.

In regards to the so-called expiration of the 25 percent rule, I think everybody on this committee that has dealt with the whole issue of cost containment has always looked on organizations such as your own, and others, that articulate so well the concerns of the Medicare beneficiaries as allies in the fight to contain costs. There has been some concern expressed that if the 25 percent cap rule expires or is eliminated, then because the members that you represent and all Medicare beneficiaries will not feel the brunt of increased cost escalation, that we will lose you as allies in this fight to create a system that has some rational cost containment and some rational health care policies.

Mr. Delay. That is right.

Mr. Donnelly. We are concerned about losing you as an ally, Frank. Are you staying or going?

Mr. Delay. I do not think there is any danger of that, sir.

Mr. Donnelly. There is no danger that if we let the 25 percent rule expire or reduce it or create some other system, that we will not have you standing shoulder to shoulder with us in trying to restrain the cost of the Medicare program?

Mr. Delay. Not at all.

Mr. Donnelly. Well, thank you. Thank you very much for your testimony.

Our next witness is Dr. W. Gerald Austen, from the American College of Surgeons.

STATEMENT OF W. GERALD AUSTEN, M.D., CHAIRMAN, PHYSICIAN REIMBURSEMENT COMMITTEE, AND VICE-CHAIRMAN, BOARD OF REGENTS, AMERICAN COLLEGE OF SURGEONS, ACCOMPANIED BY PAUL A. EBERT, M.D., DIRECTOR

Dr. Austen. Mr. Chairman, the American College of Surgeons appreciates the opportunity to testify before you this morning.

Mr. Donnelly. Dr. Austen, if you could, would you please identify the gentleman sitting to your right for the record?

Dr. Austen. Yes, I will. I am Dr. Gerald Austen, and with me is Dr. Paul Ebert.

Mr. Donnelly. Thank you.

Dr. Austen. The college and representatives of the major surgical specialty societies have completed a thorough reexamination of many of the payment policy concerns that this committee will be addressing. We wish to put before you a comprehensive set of new proposals for dealing with a number of major payment reform questions, including the problem of expenditure control.

The elements of our plan are focused principally on the quality, volume, and cost of surgical services provided to Medicare patients. Equally important, we believe that new Medicare beneficiary protections should be added to the program during implementation of this plan. In brief, this proposal consists of the following four complementary elements: One, a plan to moderate the growth in Medicare expenditures through surgical services by addressing the issue of volume and to make those expenditures more predictable for beneficiaries and the Government; two, a set of proposals for improving the financial protection of Medicare patients through changes in the assignment program; three, the development of a new, blended Medicare fee schedule for surgical services that reflects both improved measurements of supply-side or resource cost inputs, and important demand side considerations; and four, a timetable for phased implementation of the proposed changes.

At the heart of our plan is a public commitment from the American College of Surgeons, the surgical specialty societies, and their more than 85,000 members.

The volume issue. If serious steps are to be taken to moderate spending for physician services under Medicare, then some workable approach must be found to strike a better balance among fee considerations, increases in volume and intensity, and the financial protections afforded beneficiaries under the program.

We believe that physician developed standards and guidelines are needed to make reasonable judgments about the frequency, volume and effectiveness of both procedural and nonprocedural physician activities. Ultimately, if guidelines are to influence the volume of services, it will be necessary to directly link payment policies with criteria that have been developed by the profession concerning the appropriateness and the effectiveness of medical and surgical treatments.

In most major hospitals the responsibility for quality assurance and volume issues is assigned to specific medical departments with the experience and confidence to deal with these issues in terms of defined categories of services. This is one reason that we propose to address the issue of increased volume of services exclusively within the scope of surgery, and we are prepared to develop criteria to determine the appropriateness of surgical care.

Another reason for recommending the separate treatment of surgery is that tools are more readily available for addressing volume concerns about surgical services because many services related to a surgical procedure are already bundled and paid for under a global fee arrangement. This bundling of surgical services stands in contrast with the current itemization of diagnostic procedures, tests, and nonsurgical visit services.

We believe that to achieve optimal cooperation from a physician group an incentive approach is essential. We therefore recommend surgery specific accountability as ascribed in our proposal.

We also suggest that the Secretary of Health and Human Services calculate actual program expenditures for surgical services in a base year in order to determine on a budget neutral basis a surgery specific conversion factor that would be applicable to Medicare surgical services using a new blended fee schedule. For 1991 and each year thereafter, the conversion factor would be increased to reflect changes in the cost of surgical practice and changes in the general earnings level of other comparable professions.

The Secretary would be required to determine a national expenditure target for surgical services subject to the blended surgical fee schedule. In estimating this expenditure target, the Secretary would be required to take into account Medicare population changes, cost changes, and estimated changes in the expected demand for and volume of surgical services that are required by Medicare patients.

Starting in 1994, if the Secretary finds that the estimated expenditure targets for surgical services covered under the plan would yield a significantly lower conversion factor than would result from the process used to update the blended fee schedule, he would be required to submit to Congress recommendations for adjusting future updates in scheduled payment amounts applicable in subsequent years.

Patient protections. As part of our plan, we are prepared to support an expanded assignment program for surgical services. One of these changes would involve the establishment by Congress of a national income level below which the new Medicare schedule of fees for surgical services would be considered as payment in full.

The college further believes that Congress should consider modifying the assignment rules affecting patients who have no opportunity to exercise their choice of surgeons, as in the case of a patient who has an acute illness and requires emergency surgical services.

Blended fee schedule for surgical services. The College has major concerns about the use of a resource base approach as the sole basis for establishing the value of services in a Medicare fee schedule system. We believe that the exclusive reliance on input costs simply does not take into account the greater diagnostic and therapeutic value of specific services for patients, and it fails to consider other factors that play a major role in determining the value of most of the goods and services that are purchased in our society.

We, therefore, recommend a relative value scale based on a composite of supply side and demand side values using equal weighting of both sets of factors. We also believe the Congress should consider legislation authorizing the Secretary to establish a list of surgical services now provided to Medicare patients that would form the basis of this new approach to payment. Only the services that are typically provided by physicians with the necessary surgical training to perform such services would be part of the plan we have in mind.

In conclusion, Mr. Chairman, we have presented the elements of a comprehensive plan and fully intend to develop our proposals in greater detail. We look forward to continue working with the committee in addressing concerns about physician payment under Medicare.

Thank you.

[The statement of Dr. Austen follows:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS
to the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Presented by
W. Gerald Austen, MD, FACS
RE: Proposals to Modify Medicare's Physician Payment System
March 21, 1989

Mr. Chairman and members of the Committee, I am W. Gerald Austen, MD, FACS, Vice-Chairman of the American College of Surgeons' Board of Regents and Chairman of its Physician Reimbursement Committee. Accompanying me is Paul A. Ebert, MD, FACS, who is the Director of the College. The College appreciates once again the opportunity to present its view on Medicare physician payment issues.

Mr. Chairman, the College and representatives of the major surgical specialty societies have completed a thorough reexamination and assessment of many of the payment policy concerns that this Committee will be addressing. We wish to take this opportunity to put before you a comprehensive set of new proposals for dealing with a number of major payment reform questions, including the problem of expenditure control. The elements of our plan are focused principally on the quality, volume, and cost of surgical services provided to Medicare patients, although we believe that features of the plan could have broader application. Equally important, we believe that new Medicare beneficiary protections should be added to the program during implementation of this plan.

In brief, Mr. Chairman, this plan consists of the following complementary elements:

1. A plan to moderate the growth in Medicare outlays for surgical services by addressing the issue of volume and to make those expenditures more predictable for beneficiaries and the government;

2. A set of proposals for improving the financial protection of Medicare patients through fundamental changes in the assignment program;

3. The development of a new, blended Medicare fee schedule for surgical services that reflects both improved measurements of supply-side, or resource cost inputs, with important demand-side considerations, including the efficacy and relative benefits of treatments as seen by both physicians and patients; and

4. An explicit timetable for phased implementation of the proposed changes.

Mr. Chairman, at the heart of our new comprehensive plan is a public commitment from the American College of Surgeons, the surgical specialty societies, and their more than 85,000 members, to work directly with the Congress--and we hope with the beneficiary community--to reach an agreement on a broad range of physician payment goals that can be implemented in an orderly manner.

THE VOLUME ISSUE--PLAN FOR MODERATING EXPENDITURE GROWTH

Mr. Chairman, if serious steps are to be taken to moderate spending for Medicare services, including the services of surgeons, then some workable approach must be found to strike a better balance among fee considerations, increases in volume and intensity, and the financial protections afforded beneficiaries under the program. This, it seems to us, is far more important than focusing attention almost exclusively on how payments should be distributed among different categories of physicians.

If we are going to be realistic, Congress must recognize that spending for health care probably will continue to rise, even if all hospital and physician payments were to be frozen at today's price levels. After all, the total number of Medicare beneficiaries is increasing every year, and the average age of the older population in this country also is rising, so that the demand for medical attention from the elderly can only be expected to increase as well. Moreover, changing medical technologies, better diagnostic techniques, and improvements that enhance the quality of life for older patients also contribute to increased Medicare spending for health services, and few would suggest that the aged--but not the young--should forgo these benefits. The major policy problems for the Congress, as we see it, are to determine by how much spending growth can be moderated without serious consequences for aged patients and whether such costs can be made more predictable.

Up to now, two general methods for reducing health spending have been discussed--either reducing the unit prices (or fees) of physicians' services or reducing the volume of those services.

The volume of physicians' services obviously reflects judgments about medical necessity that are influenced by the state of medical knowledge, and also, in part, by the professional liability climate. We believe that more physician-developed standards and guidelines are needed to define office and outpatient practice patterns relating to specific diseases, such as those that have been developed for a number of operations provided in inpatient settings. Criteria also are needed to make reasonable judgments about the frequency, volume, and effectiveness of both procedural and non-procedural physician activities. Ultimately, if guidelines are to influence the volume issue, it will be necessary to directly link payment policies with professionally developed criteria concerning the appropriateness and the effectiveness of various medical and surgical treatments. Our plan is premised on the establishment of such a linkage for surgical services provided to Medicare patients.

Those of us in surgery believe that it is impossible to effectively and efficiently address the volume issue across the entire spectrum of medical services. In most major hospitals, the responsibility for quality assurance and volume issues is assigned to specific departments with the experience and competence to deal with these issues in the context of specific service categories. It is for this reason that we propose an attempt to address the issue of increased volume of services exclusively within the scope of the specific specialty. At the present time, the volume of services paid for by Medicare is increasing at a rate that exceeds the increase in the aged population. In our view, Medicare will have greater success in dealing with this issue if the program follows the present examples within the medical profession for evaluating the appropriateness and quality of services.

We believe that major steps can be taken now to moderate the growth in Medicare spending, if the government will join with the surgical profession to make such a plan work. Working with the government, we are prepared to develop criteria to determine the appropriateness of various surgical treatments and to assist, as appropriate, in applying such criteria to determine payments for those services under Medicare. Furthermore, we are prepared to help identify unnecessary, outdated, or inappropriate services on a specialty-by-specialty basis.

In addition, we suggest another tool for moderating the expenditures for surgical services. Under this approach, the Secretary of Health and Human Services would calculate actual program expenditures for surgical services in a base year--perhaps 1989. From these amounts, the Secretary would be directed to determine on a budget-neutral basis a surgery-specific conversion factor that would be applicable to Medicare surgical services, using a new, blended fee schedule for Medicare surgical procedures to be described later in this testimony. Under the plan, this 1989 conversion factor would be updated for 1990 so as to remain budget neutral with respect to any expenditure goals for Medicare set forth by the Congress for that year.

For 1991 and each year thereafter, the conversion factor would be increased to reflect changes in the costs of surgical practice, including professional liability costs, and changes in the general earnings levels of other comparable professionals.

The Secretary would be required to determine a national expenditure target for surgical services subject to the blended surgical fee schedule. In estimating this expenditure target for 1991, the Secretary, in consultation with representatives from beneficiary organizations and professional organizations of surgeons, would be required to take into account:

-- population changes, including the total number of beneficiaries covered by Medicare, the age distribution of the enrolled population, and factors affecting morbidity;

-- cost changes, including costs relating to the increased use of new technologies, and cost changes reflected in a market-basket index of practice costs (e.g., expenses for professional liability insurance) relating to surgical services; and

-- estimated changes in the expected demand for and volume of surgical services that are required by Medicare patients.

Starting in 1994, if the Secretary finds that the estimated expenditure target for surgical services covered under the plan--taking into account the factors just described--would yield a significantly lower conversion factor than would result from the process used to update the blended fee schedule, he would be required to submit to Congress recommendations for adjusting future updates in scheduled payment amounts applicable in later years. In the event that the Secretary makes such a finding, he would be required to consider the views of the Physician Payment Review Commission (PPRC), the surgical community, and beneficiary organizations in developing his recommendations.

We believe that a thirty-six month interval between the effective date of the first phase of the plan--i.e., use of the blended surgical fee schedule--and the setting of the first target expenditure goal is needed in order to develop the infrastructure and data base within the surgical community that would be required for an effective program of volume assessment and compliance with professional standards. We are prepared to make a commitment to develop the needed infrastructure within the surgical community to make this plan work.

PATIENT PROTECTION PROVISIONS

Mr. Chairman, the principal purposes of the Medicare program are to provide our older citizens with access to high quality medical care and with reasonable economic protection against the costs of those services. We believe that major changes in payment policies under the program for hospital and physicians' services must be considered with these goals in mind.

As you know, a significant number of our members and other physicians are participating physicians under Medicare and currently accept assignment in all Medicare cases. A much larger number of physicians, who have some objections to signing participation agreements, nevertheless frequently accept assignment for older patients, and particularly for those with more limited means. Thus, it seems appropriate to reexamine Medicare's current assignment experience and consider ways to improve the financial protection for surgical services afforded by Medicare under a new payment approach. Physicians wishing to sign participation agreements or to accept assignment in any other cases would be allowed to continue to do so under our plan.

Under the plan we propose, surgeons--working with beneficiary organizations and with the Congress--are prepared to support changes in the current assignment procedures under Medicare. One of these changes would involve the establishment by Congress of a national income level below which the new Medicare schedule of fees for surgical services would be considered as payment in full. Medicare would pay physicians 80 percent of the scheduled payment directly and the patient would remain liable for only the 20 percent coinsurance. No additional charges to qualifying patients could be made. Physicians would be permitted to charge their regular fees for all other patients, subject to Medicare's existing rules.

There are obviously some administrative considerations that would need further study to avoid claims problems for physicians and to protect the privacy of patients. But we believe that these difficulties can be overcome in a workable manner and are prepared to discuss a number of options with Congress about how to implement such a plan.

The College further believes that Congress also should consider the assignment rules affecting patients who have no opportunity to exercise their choice of surgeon, as in the case of a patient who has an acute illness and who requires emergency surgical services. Where no choice of a surgeon is available, the patient has no real opportunity to obtain the most favorable fee options, so that some patient protection against higher charges might seem warranted in such cases. We are now studying this proposition in more detail, but are not as yet prepared to recommend a specific way to address this issue.

Lastly, Mr. Chairman, we are concerned about the effects of any new valuation process that results in Medicare paying an above-market current price level for services and, thereby, potentially increasing the costs of those services for patients and, perhaps, the government, too. For example, if increases were to be made in Medicare's allowed amounts for some services, but not made in the maximum allowable actual charges that also apply to those services, the effects on patients will be mixed. The coinsurance costs for all patients for these services will rise, though any extra billing costs for non-assigned claims would be reduced. The premium costs for all enrollees also will increase as well. Thus, we believe that Congress should take steps to ensure, in some clear fashion, that Medicare patients benefit from steps that increase Medicare payments for certain services so that beneficiaries will not be unduly burdened by also paying a substantially larger copayment.

BLENDED FEE SCHEDULE FOR SURGICAL SERVICES

Mr. Chairman, an integral element of this proposal provides for the establishment of a blended fee schedule for surgical services under Medicare that would strike a balance between both supply-side and demand-side factors in determining relative values for the services covered under the proposed plan.

We wish to make clear that we support the use of a relative value scale in any Medicare fee schedule system. However, as the members of this Committee know, the College has major concerns about the use of a resource-based approach as the sole basis for establishing the value of services in such fee schedules. In general, we have felt that, among other things, this approach simply does not take into account the greater diagnostic or therapeutic value of specific services for patients, it ignores the quality of the services provided, and it fails to consider other factors that play a major role in determining the value of most other goods and services that are purchased in our society.

Moreover, no relative value scale, including the Harvard approach, offers any real solution for moderating the costs of medical and surgical services under the program. In fact, one of the effects of the Harvard RBRVS could be to raise Medicare fees paid to some physicians well above the levels they now charge or are paid by other private insurers for providing the same services. As we have noted, we believe that this would significantly increase the costs of those services not only for the government, but also for patients through higher premium and coinsurance costs. It also seems to us that substantial increases in payments for any services not only would increase the unit cost of those services, but also would provide strong financial incentives to increase the volume of these services. Without a plan for dealing with these volume effects under a resource-based approach, we believe Medicare costs would rise even more rapidly than they have in the past.

On the other hand, the major relative value reductions proposed under the RBRVS approach, including the effects on many procedural services, could seriously affect access to some physicians' services and reduce the interest of many physicians in signing Medicare participation agreements or accepting assignment.

We want to make it very clear, however, that we do not oppose using supply-side considerations, or resource input costs, as one factor in determining the value of services provided by physicians. Obviously, all physicians must carefully take into account such matters as their costs of practice when they establish their fees. Surgeons, for example, are especially aware of the effects of professional liability costs on the fees they must charge patients for their professional services. But, we believe that relying exclusively on physicians' judgments about the input costs of services in order to set relative values is conceptually incomplete. We also believe that there are special problems in surgery, such as professional liability costs, that need to be considered carefully in constructing any cost of practice adjustments in fees for surgical services.

Therefore, we propose the development of a fee schedule for surgical services that would take into account not only the supply-side considerations reflected in a resource-based approach to payment, but also important demand-side considerations and the interests of patients that should not be ignored in the process of setting values.

To start, we believe that the Congress should consider legislation authorizing the Secretary to establish an explicit list of surgical services now provided to Medicare patients that would form the basis of a new approach to payment for those services. Non-operative invasive procedures that may be provided by both medical and surgical specialists would not be affected by the plan. Thus, only the services that are typically provided by physicians with the necessary surgical training or experience to perform such services would be part of the plan we have in mind. On the basis of our preliminary study of Medicare data and the scope of this plan, we estimate that surgical services covered by the proposal account for about 30 percent of all expenditures for physician services under Medicare.

Under our proposal, we anticipate that further efforts will be made by the PPRC and the Secretary to improve upon the methodology used in the Harvard RBRVS project to yield a more valid set of estimates of the resource costs involved in producing physicians' services. We also anticipate that recommendations will be made concerning those aspects of the Harvard RBRVS project that need further refinement, as well as the aspects that can be implemented more quickly. This is of concern to us, since not all of the surgical specialties were included in the initial phase of the Harvard project. Moreover, some of the results from the first phase need to be reexamined before the RBRVS results could be used.

We also believe that the Congress should direct the Secretary to conduct research into those factors that should be used to establish demand-side considerations affecting relative values for surgical services, including such possibilities as looking at market prices for services, the efficacy of alternative treatments as measured by data on such matters as mortality reduction and adverse consequences of treatment, and the importance of treatments to patients. Even the Harvard researchers seem to think there is merit in looking at physician charge data as a basis for making relative value calculations within different families of physicians' services.

We do not think that you will have to wait very long for the results of the Secretary's work in this area in order to identify and develop the kinds of information needed about demand-side considerations to determine relative values for the services that would make up a new Medicare fee schedule for surgery. The results of the Secretary's investigations in this area would be used to develop a new, blended schedule for surgical services provided to Medicare patients that would be applied as early as January 1991. Should the Secretary's work on demand-side factors not be ready by that time, we believe that physician charges could be used in the interim as a "rough" approximation of demand considerations.

In our view, the relative values of all physicians' services should be based on a composite of supply-side and demand-side values using equal weighting of both factors. However, we obviously cannot speak for other physicians on this point and, therefore, have limited our recommendations for a "blended" approach only to those services performed by surgeons.

PHASED IMPLEMENTATION

Mr. Chairman, we believe that rapid implementation of major payment reform changes could adversely affect patients by increasing some of their costs or perhaps by limiting their access to services. Thus, we have urged this Committee and other policymakers to proceed carefully and in stages to bring about significant changes in payment policy. These considerations suggest that major reform actions should be put in place over a reasonable transition period. We have developed a preliminary implementation schedule for our proposals consistent with these goals.

The major changes for which phased implementation seems appropriate are, first, to substitute the blended fee schedule for surgical services for the current reasonable, customary and prevailing fee-based methodology and, second, to implement the expenditure target program, including the development and application of criteria for judging the appropriateness and effectiveness of surgical services.

As noted above, the blended fee schedule for surgical services would be developed for use beginning in 1991. Under the plan, movement toward the full 50/50 blend of supply-side and demand-side considerations would commence in that year and be completed by 1996. In the interim, relative values based on current charges would be phased in with the new, blended values calculated by the Secretary for Medicare surgical services. The weight assigned to the new, blended values would increase steadily during the transition period, while the weight assigned to current charges would decrease gradually, as follows:

Year	Current Charge Weight	Blended Schedule Weight
1990	6/6	0
1991	5/6	1/6
1992	4/6	2/6
1993	3/6	3/6
1994	2/6	4/6
1995	1/6	5/6
1996	0	6/6

We believe that a less lengthy schedule is needed for phasing in geographic differentials under a blended fee schedule, with three years perhaps being a realistic goal after the data became available to make such adjustments. Both the differential used under Medicare's current methodology as well as a differential used under a reformed approach would be used. A composite rate of the two differentials would be calculated and phased in as follows:

Year	Current Differential Weight	Reform Differential Weight
1990	3/3	0
1991	2/3	1/3
1992	1/3	2/3
1993	0	3/3

We have not proposed a specific transition schedule at this time relating to the volume of services issue. We recognize, however, that the expenditure target provisions contained in our plan place the responsibility squarely on the surgical community to develop effective criteria for determining the appropriateness of care and for obtaining compliance with those criteria. Thus, we propose that the Secretary, after receiving further advice from the PPRC, from organizations representing surgery, and from groups representing beneficiaries, develop a reasonable schedule for implementing proposals relating to volume.

SUMMARY

In conclusion, Mr. Chairman, we are recommending a comprehensive plan for addressing the pricing and volume of surgical services under Medicare, and for providing important, new beneficiary financial protections. The key features of our plan are:

1. A fee schedule for surgical services under Medicare based on a 50/50 blend of resource costs and demand-side factors, effective in 1991;

2. An increased emphasis on the development, dissemination, and application of practice guidelines, coupled with a determination of a national expenditure target for surgical services, effective in 1994;

3. Payment for services provided to Medicare patients with incomes at or below a level determined by Congress on the basis of the scheduled payment amounts only; and

4. Phased implementation of the new payment system, beginning in 1991.

We fully intend to develop our proposals in greater detail. American surgery is committed to a constructive role in advising and participating with the Congress, the PPRC, and the Secretary in developing the initiatives that are necessary to moderate costs and to maintain the quality of, and access to, surgical services. The specific concepts presented in this proposal have been discussed with the leaders of ten surgical specialties. They have unanimously agreed to the formation of a Conjoint Council on Surgical Services to assist in further refinement of this action plan. These societies are:

American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology--Head and Neck Surgery
American Association of Neurological Surgeons
American Association for Thoracic Surgery/The Society of Thoracic Surgeons
American Pediatric Surgical Association
American Society of Colon and Rectal Surgeons
American Society of Plastic and Reconstructive Surgeons
American Urological Association
The Society for Vascular Surgery/International Society for Cardiovascular Surgery

Chairman STARK. Gerry, thank you. I am sorry I was out of the room when you started your testimony. But can you go back for me on the demand/supply side. I think I should let our resident economists, Mr. Moody and Mr. Levin, deal with that. But as I understand those who devised the Hsiao relative value scale study, by taking into a lot of factors, came up with an index. Basically, this was per procedure and then they sort of blended that into how many procedures you do.

How do you differ with how you arrive at your scale versus how Hsiao arrives at his, in layperson's terms?

Dr. AUSTEN. Well, I think in the simplest terms what we are saying is that the input cost, which represents the total elements in the Harvard study approach, the input costs we think, obviously, must be considered because they are obviously very important. Our view, however, is that they are not alone. The only thing that ought to be considered in deciding what a service should be—what the price of a service should be, and we feel that the value, basically the value of a particular service as seen by the patient should also be considered in determining what the value of the service is, just like almost everything else that we put a value on in this country.

Chairman STARK. I guess my problem with that is that you would be hard right now to come up with, this morning—I am sure many of the witnesses have a lot of surgical procedures they would like to apply to me, but I can't think of any as I sit here feeling pretty good today that I would give you a dollar for.

But, on the other hand, if I were aching or threatened with death or I had been chopped up by an Uzi in my district, there would probably be no price that you couldn't extract from me while I was laying on the gurney in the emergency room. I just wonder, how do you see the patient trying to assess what you would do for them? Give me a for instance on that.

Dr. AUSTEN. Perhaps the best way for me to answer that is to tell you a little bit about what I would have in mind in terms of determining this demand side part. I think basically what we are saying is a little bit related to what was said earlier in the testimony; namely, there is some insecurity whether using the resource cost will turn out to be a completely fair pricing arrangement. And in a way, perhaps that is what we are saying.

What I would have in mind is that the demand side part would be determined by a consensus group, and that consensus group would include Government representatives, it would include the physician representatives, and it would include the beneficiaries. And, obviously, the decisions would not be made when the patient is ill, but it would be made in a situation where there could be discussion and some clear thinking as to what was appropriate.

Chairman STARK. OK. I want to just press a little bit further. How would you see the demand side, just in your personal opinion, between, for instance, cosmetic surgery for droopy eyelids which seems to me to be very subjective and is not a very critical, preelective sort of thing, and something that has to come out because it is diseased or malignant.

Do you see this group saying, obviously those are more necessary and we shouldn't have the overpriced elective surgery? I can see from your side that you all know what is tougher surgery to do, and you can argue among yourselves in the quiet of the room where we don't have to listen to the gory details. But I mean, basically that makes sense.

I can't figure out how I could decide with you, if I were a part of this, whether I think a gallbladder or a hip replacement——

Dr. AUSTEN. It is not an easy thing to do. I agree with that.

Chairman STARK. Why does it have to be in there? I mean, why can't you guys decide that? If you don't like the relative value scale among yourselves, wouldn't it be simpler for you to say let's go back to the drawing board with Dr. Hsiao and those folks and let the surgeons and the radiologists and the internists go back and have at it a little longer to come up with a scale that you are comfortable with? Or just the surgeons? I mean I have no quarrel with people saying, "Well, the cognitive guys just don't understand the stress and the strain we are under, and the manual dexterity which is not necessarily part of a cognitive thing, and we want to have a separate scale among ourselves." But you interject this third function which I have trouble, seriously, understanding quite how it would work.

Dr. AUSTEN. Well, of course, in our proposal, in actual fact this would be done in the surgical community, which we feel makes it much easier in terms of being able to talk the same language, in any event.

Chairman STARK. What do you anticipate among your members—how are you going to enforce compliance? What do you do about those people who perform the procedures which I suppose are the least critical ones but among family practitioners or others who may do this incidental to another practice? Do you kick them out of the club if they don't toe the line?

Dr. AUSTEN. Let me begin, and then I am going to ask Dr. Ebert to also answer that question.

I think that whole area of compliance, which is clearly a problem, and the problem related to that has been alluded to in earlier discussions. We think that one of the great advantages of having a separate surgery relative value scale is the fact that surgeons would be determining the guidelines and the standards. They would be communicating those guidelines and standards to their associates, to the other surgeons in this country, and we would presume that those guidelines and standards would have sufficient clout that that would, as we indicated in our written testimony, that that would—that payment would be based on those guidelines and standards.

There, obviously, would be exceptions, and those exceptions would have to be dealt with individually in terms of surgeons feeling that a particular procedure ought to be done in spite of the fact that it did not adhere to the guidelines.

Chairman STARK. OK. Do I understand your position on expenditure target that you want to see yours as a fixed percentage?

Dr. AUSTEN. Well, we are suggesting that a particular group of services, and that would have to be defined by Congress presumably, that a specific group of services that we will call surgical services would be determined and the amount of cost of those services to the Medicare program would be determined in a base year, and that would then be the control year.

Chairman **Stark**. OK. But what if I changed it this way? Let's say that, just for talking purposes, that in calendar year 1988 out of a billion dollars, $300 million was part B and that was all doctors fees. As I sense what we would do with PhysPRC is we would say: Look. That went up 15 percent last year and that is too much. And inflation was 4, and the doctors will say: We can't live with that. So, we go back and forth and back and forth and we come up and say 9 percent. Everyone says: OK. We will try 9 percent.

Dr. **Austen**. Yes.

Chairman **Stark**. OK. Now that is what I think PhysPRC is talking about. Then if you all as a physicians' community didn't meet that target, then next year we would give you a little less because you didn't meet what you agreed to this year.

Now, as I understand, what you are saying is that out of the $300 million in 1988, surgeons' services were to receive half. They would get $150 million of it. OK?

Dr. **Austen**. Right.

Chairman **Stark**. We want to hold it at half. Then we want to take our half and divide it up. I am not sure I have any problem with this, but I am not sure it is any better. I don't like the idea of a fixed percentage, say, going to—let's take you guys out of the loop and say radiologists. That just because 20 percent of everything we have been spending historically goes to radiologists that we ought to project that on into the future. Because maybe with changes in medicine, in increased productivity we could drop that.

But I am not sure that we couldn't negotiate with, say, three groups—the surgeons, the primary care people, such as family practitioners and internists, and then all the ancillary or what I call the lab workers, pathologists, anesthesiologists, radiologists, and say without relation to the other now, now you are all on your own. We will negotiate with each group separately each year, and you don't relate through what you had in the past because practices may change.

I am not sure that I want to do that. I would rather have you guys fighting among yourselves because you know what you are talking about. But isn't that kind of halfway between what you are suggesting and what Phil is saying, dividing you into three groups which tends to have a more common practice and training? How does that differ from what you are doing, and what does that do to your plan?

Dr. **Austen**. I would like Dr. Ebert to answer that.

Dr. **Ebert**. I think we chatted once before on this. I think the arena really is that if an expenditure target up or down, whatever, per year we are fairly certain that the volume of surgery per se in the in-hospital portion has been fairly stabilized. We think that the volume question per se, although it increases with population and increases as to percent of the elderly increases—there are more 82-year-olds——

Chairman **Stark**. Let's stipulate that all of this is adjusted for population increase.

Dr. **Ebert**. The majority of guidelines that have been created up to now and the majority of quality assurance programs have focused predominately on inpatient services, and surgery is the predominate source of that. So we think we have more of a mechanism and infrastructure in place.

There is also a dichotomy of discussion that went on earlier this morning on this question, and that is, that the incentives are often applied to the idea that certain procedures, they didn't say just operations, but certain procedures are overpriced and thus there is an incentive to do more of these. Concurrently, now we are seeing a discussion brought out that says let's readjust within the arena. Now wouldn't that same logic apply that volume may well increase in areas that are going to incur higher price.

We are very concerned that a system that is increasing as much in volume as this that we think we have a better opportunity within surgery to at least address that issue. And I think we said if we accede to target, then a conversion factor should be decreased in the subsequent year to take account. I am assuming you took account for all the other adjustments you put forth.

Dr. AUSTEN. We are sort of saying I think that all of medicine is just too big to kind of control this, and we think that we have a real chance to do it in a particular area, in this case surgery, and we think it is going to be awfully hard to get much incentive into a system where there are this vast number of people and number of procedures how can surgery really have much of an effect on the outcome when actually it is about a third of the services.

Chairman STARK. How many cases, Gerry, does the primary care person have an impact on the decision as to whether or not there will be surgery? Is that always the—90 percent the surgeon's decision, 70 percent?

Dr. AUSTEN. Well, in the final analysis it ought to be 100 percent the surgeon's decision. Obviously, he is working with another individual who usually refers the case to him, and so there certainly are pressures.

Chairman STARK. So you accept both the benefits and the responsibility for saying if there is overutilization in surgery it is the surgeons, not the referring physicians?

Dr. AUSTEN. Absolutely.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you very much, Mr. Chairman.

On the blended proposal, how do you argue in kind of macroeconomic terms having a blended schedule for surgery but not for other procedures?

Dr. AUSTEN. Well, I think our view is that we can't speak for other areas of medicine. We have honestly given our view about the areas that we know about for the regions that we have indicated.

I might say in some ways the PhysPRC has certainly made a nod a little bit in the direction that we have talked about because, if you want to be a purist, the Harvard study is in terms of the outcome now is somewhat different. The PhysPRC recommendations are somewhat different than the initial resource, pure resource-based RVS that the Harvard group first presented.

Dr. EBERT. Mr. Levin, could I just answer? If you go to a target expenditure for surgical services, most of the time in surgery we have little trouble within the field of surgery all the way across for all the specialties arriving at a scale of an RVS that we are comfortable with, and whether it is a blend, whether it is a resource or whether it is—whatever name you wish to give it, I think as long as it fits into the particular target and there is comfort level among the groups that are dealing with it. We have a larger comfort group within the surgical specialties dealing with an RVS that is blended than we do going all the way across medicine and looking at a resource-base-only system.

Mr. LEVIN. As I understand the proposal, that would be affected by the target being set on the basis of a blended system. You want the target to include factors other than a resource-base system so that the pot increases in amount.

Dr. EBERT. No, not—well, the target would be built on the scope of surgical services that were done in whatever reference years you chose to select.

Mr. LEVIN. But still the value of them, you want based on what was charged.

Dr. EBERT. What was probably paid by Medicare because that is the only data we have.

Mr. LEVIN. But what is being paid includes more than the resource-based system. So, I mean, naturally you are going to say okay, we will take a target expenditure as long as you set it so that it is adequate to take into account more than it would have been on a resource-based system now. I think that is what you are saying.

Dr. EBERT. Well, I would say there are several of the surgical specialties that actually increase their standing under the PhysPRC's resource-based or blended schedule. We are just saying that the comfort level within the surgical specialties would be better if we created a blended schedule rather than taking one that is being created outside.

Dr. AUSTEN. This is comparing one procedure to another.

Chairman STARK. Would the gentleman yield?

Mr. LEVIN. Yes.

Chairman STARK. Let me see if this isn't, in a sense, what you are saying. With the relative value scale, the surgeons generally came out at the high end. The highest end of the scale. So if you are going to go all the way to relative value, the surgeons would take the biggest hit. But if another word for demand is current fees, as being what the public will pay, then the closer they can stay to that the less impact it will have on surgeons' income.

Now what I hear these gentlemen suggesting to us is that they should go halfway. Not a bad compromise. But what they are really saying is, OK, we will take half the hits, if that is how it really comes out, of the relative value decrease, but like the DRG argument. Let's say half are at the old rate and half at the new rate, and half at the current reasonable and necessary rate. You don't get that good an offer from a car salesman the first time out of the box.

What I am suggesting is that what I am hearing, and I am looking for some nods from the witness stand, is half. And that is more than I have heard from any other group.

Mr. LEVIN. I think that is essentially correct. Isn't it? The question is how you justify it other than in very practical terms. Because you are essentially saying that the surgical part will blend but not for the others, and the reason is you construct a theoretical basis for it. For example, you say that this approach does not take into account the greater diagnostic or therapeutic value of specific services for patients, but that would be true of nonsurgical.

If you go to a simply resource-based system—and, Mr. Chairman, this is in response to your description—you can make the same argument about nonsurgical. Right? And the same with—it ignores the quality of the services provided.

Dr. AUSTEN. Correct.

Mr. LEVIN. And then the third factor, it fails to consider other factors that play a major role in determining the value of most other goods, you can say that also. So, essentially, while there may be a practical value, kind of a hands-on approach to this, getting ourselves out of it, there isn't yet really a conceptual construct to justify having a blended system for surgical and a nonblended for everything else.

Dr. EBERT. Well, 2 years ago we testified and put forth a proposal before this committee that had a total created demand side charge-based RVS and that has never been embraced by other portions of the medical profession. So, as Mr. Stark replies, I think we have come 50 percent in that direction. But I suspect, depending on the outcome of any RVS you put forth, you are going to have some parts of the profession in favor of it and some are not in favor of it.

Mr. LEVIN. Let me just ask you, in terms of the 50 percent blending, you say it is based on the value to the patient. That really would not explain the wide differentials in the charges from area to area for the same kind of service. Right? I mean, what we are really talking about is what the market condition is and all the reasons for the market; it isn't the value to the patient alone.

I take it cataract surgery is worth the same to patients in Michigan as it is in California.

Dr. AUSTEN. Well, we certainly agree that where there have been geographic variations and other variations that are inappropriate that they ought to be corrected, and we have said that from the very beginning.

Mr. LEVIN. How do you do that if you blend 50-percent factors other than resource based? How are you going to squeeze out the wide differentials?

Dr. EBERT. Well, if you have a national RVS, you are going to take an awful lot of that into account. An awful lot of the wide variations that you see now are, strangely enough, they are not necessarily in the Medicare payments near as much as they are in the third-party areas around the country. If you have got statewide variations in Medicare, actual payments, it is a much narrower scope than one originally anticipated it being. Because we proposed that 2 years ago as well, and we found that there wasn't near the wide scope that one might have anticipated in that.

So I think with a national RVS you will have to have some, I assume some regional modification to it for cost of practice or whatever is determined on a payment area. But you will most likely narrow those differences even further.

Dr. AUSTEN. We are for a national relative value scale.

Mr. LEVIN. I understand that.

Well, it will be interesting to take your blended system and apply it to surgical charges where there is a considerable discrepancy and see what would—what the result would be. I think since we are talking practically for the moment, the answer is the deferential should be more or less cut in half. And you would still—where there is a wide discrepancy, you would retain half of it. Right?

Now, how do we justify that?

Chairman STARK. Well, if the gentleman would yield, the other part we have got to deal with—and this is part of what they are suggesting, as I understand it, and they are not far away from PhysPRC on this, is the volume cap, if they are willing to negotiate.

Mr. LEVIN. Yes.

Chairman STARK. So I guess we maybe have to look at that. They, I am sure, are not going to ask us to reduce below what the aggregate would be. Now what they are saying—if I get this correct—is that they want to negotiate the volume cap separately, separate from the other physicians. And Phil Lee I think said that maybe we should start with a national cap and eventually let the various specialties be part of that.

Mr. LEVIN. Yes.

Chairman STARK. That seems very close.

Mr. LEVIN. No, no, fair enough. I think the answer to my question in part is that the discrepancies could be further squeezed by the negotiated cap. But you need to help us—I am asking these questions not because I think you are wrong, but I want to see if you are right. And you need to help us put these pieces together.

I think you know what the problem is, that you have come here representing the group that would be most hit. And the notion is that you are looking for a construct that would protect as much of the present differential, whatever you want to call it, as possible. And that you are kind of working backwards in that we end up with a kind of a fancy structure that really had a very practical solution to it.

There has to be some internal consistency though. And I think you need to work out these ideas and show us the quality in it as well as the quantity.

Dr. EBERT. I would just add, Mr. Levin, I think our main parts of the proposal really are related to the targeted expenditure, and addressing—we think anyway—the question of volume both by—as has been said many times, whether it is practice guidelines, whether it is quality, inappropriate services, whatever. And to us, we just—we feel basically the RVS part of it, if you accept the idea of a target for a particular specialty, the RVS will probably be solved within the specialty easier than it is solved at a national external commission level.

Mr. LEVIN. Thanks.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Thank you, gentlemen for your fine testimony.

I would like to just talk and visit a little about the issue of volume. To me that has always been the most difficult issue, although I think on face value it looks like the easiest way to handle increased expenditures. But in reality, it is the most difficult way to do that because we have to make—as do our beneficiaries have to make—some judgments about decisions you people make. And I am very uncomfortable doing that because we not only have a fiduciary responsibility to the beneficiaries, we also have a commitment that they get quality care.

Can you expand a little bit on your recommendation of where you would like to see surgeons go in volume. Because I think some of the things you are saying make some sense to me.

Dr. AUSTEN. Well, I am not quite sure how you would like us to expand it. Our view is that——

Mr. DONNELLY. You want to be separated out from a national——

Dr. AUSTEN. We want to be separated out from all of medicine because we believe that by having surgeons creating the guidelines and then publicizing those guidelines and in—we think that is the best way of getting all of surgery together to most effectively limit volume and eliminate excesses that are in the system.

Mr. DONNELLY. But as difficult a judgment as it is for people like myself to make those objective judgments on volume, is it not going to be as difficult for your profession? Is it not indigenous in your professions because you have such great respect for your colleagues that it is going to be difficult for you also internally to have to deal with that issue of when and what and how many are the right procedures?

Dr. AUSTEN. We agree. We think this is going to be difficult. We believe that we have a good chance of being able to do it and we think in some ways it is going to be easier to be done in the surgical areas than in the nonsurgical areas, because we have kind of a head start on it in terms of a global fee concept, and also they are limited in terms of numbers of services that surgeons provide as opposed to the millions and millions and millions of services that are provided by nonsurgical services.

Mr. DONNELLY. Doctor.

Dr. EBERT. I would only—I think we do not necessarily make your life any easier when we offer a segmented component such as this, but we do not recognize it——

Mr. DONNELLY. I am not so sure we are going to be making your life any easier.

Dr. EBERT. No. I agree. But I think the true peer review within the profession has always been accomplished by individuals generally speaking with comparable training, comparable experience, and usually some geographic separation so they are not looked at too closely. And I think that is what the colleagues have always supported has been quality service. And I think we can offer that in a more liberal fashion to whatever mechanism you or HCFA chose implement, guidelines, whether it be PROs or whether it be on preadmission workups or whatever.

We recognize we may not be making our life easier. We recognize we may not reduce volume per se. But we are willing to say on the other hand that if it is not, than the financial responsibility should not be passed on to the beneficiary, it should be incurred, assuming Mr. Sherman keeps the proper adjustments to inflation and other things.

Mr. **Donnelly**. Well, according to the Bush budget, there will be very low inflation anyhow so we do not have to worry about it.

I want to ask Dr. Austen a question on malpractice because it is such a problem in Massachusetts.

What effects do you think that this increased cost of malpractice insurance coverage has on physicians' need to get a greater reimbursement for service for one of their Medicare beneficiaries? Because I hear from the doctors at home all the time, because we have mandatory assignment in Massachusetts, they will say, my God, I am paying tens of thousands of dollars for malpractice insurance, and I have this rich nice little old man come in and I cannot charge him an extra dime other than what you people decide I can charge him. I mean, that is a portion of it, is it not?

Dr. **Austen**. I would have to agree with that doctor who spoke to you. It is a very big problem for us in Massachusetts, as you have indicated because we sort of have no place to go in terms of recouping our costs.

Mr. **Donnelly**. But then, doctor, there is this question: do you go to the Medicare beneficiaries? Is it not a fact that the smallest percentage of people that you treat who end up taking you to court are Medicare beneficiaries?

Dr. **Austen**. I do not know anything about that. But that may well be true.

Mr. **Donnelly**. So what is happening because we have this system that is totally out of control—I could not agree with you more in terms of the costs and the whole procedure with malpractice insurance both in its cost and the way that it goes through the judicial system—that this system is forcing a movement for higher reimbursement because of the cost that is really not the fault of the people.

Dr. **Ebert**. We were very happy with the PhysPRC's recommendation that the malpractice be at least accounted separately if possible. I think it would be terribly important for Congress to know what percent of the Medicare dollar you are spending indirectly through the physicians for malpractice premiums.

Mr. **Donnelly**. We have a responsibility to take care of our own, those beneficiaries. We have no responsibility for anybody else in this instance.

Dr. **Ebert**. That is right.

Mr. **Donnelly**. And I would hate to see the Medicare beneficiaries being charged for problems created by other folks. And it is something that I think the committee can persue.

Thanks very much.

Chairman **Stark**. I would just like to discuss a couple of issues. And we are going to ask the AMA to come and testify at that time and you might want to respond later since in the past this committee, for example, has had the reluctance to get in direct negotiations between ophthalmologists and heart surgeons. We are just not competent to make those decisions. Consider the possibility of just going back to PhysPRC and saying negotiate—recommend to us caps, but set up another group—in other words, negotiate that first with say three groups and make PhysPRC the group who would then in fact negotiate with, for example, the surgeons, primary care, and lab, so that you take Congress out of the loop of having to make decisions that we are not equipped to make.

Second, I am not so sure that the 50 percent present reasonable and necessary fees and 50 percent of some RVS we could not say in different ways through some kind of a phase-in. I see that you and PhysPRC are very close in that regard. And as long as there is agreement in the physicians' community or as a group as to the relative values in fairly large groups, it would be a matter of a difference to me how we phased it in, and that maybe we could get more to where you want to be and what is being recommended to us.

Now, having recognized how long we postponed phase-ins in the DRGs, I would hope that we would have a kind of a drop dead phase for these things to fall into place.

The third thing that we have not discussed at all—and perhaps it would be very important to us as this system is phased-in, and I think will be somewhat abhorrent to you your members, but I hope you will consider this. Phil Lee referred to electronic billing as a way for us to have electronic controls and information. That becomes very important to us.

What are we going to have to do to get your members to be happy campers and sign up? What I am thinking of is a tradeoff like quicker payment, instant credit to the account to be later charged retrospectively. If we find overutilization, we can come back and audit. But I am willing to put a carrot out there if we could get cooperation.

We have not gotten any data it from the hospitals, but sooner or later we are going to have to have that data to make all kinds of choices. And it seems to me wrong that HCFA does not have current data on a lot of things. And your cooperation would be helpful. And that might get us, I think, down the line.

The fourth thing to think about—and again I would like your comments on this later—but it has occurred to the chair—I do not have an overwhelming groundswell of support from my colleagues on the committee—that we are in an excellent position here if we can stand the heat from the trial lawyers to just say no more malpractice for Medicare. If you are a Medicare beneficiary, you go through some kind of arbitration procedure first.

You cannot, obviously, as I say, deny them the ability to sue at some point. But for hospitals and doctors, just say wait a minute, there has got to be some kind of a—various States have these programs for arbitration. And if we could figure out how much that would save us. We are paying for it. One way or another, the Government is paying for it. Because your costs or your bills go up to comp. If we at least for the Medicare part of your practice, get that out of the system. I would love to hear how you would react to that and in what States you know where that works well. It would be really helpful to us if we are going to do that.

Thanks very much.

Dr. AUSTEN. Thank you.

Chairman **Stark**. I hope we can work together, because I think that there is a lot that we can do here, and I certainly appreciate the effort you have put into this plan. I hope that we will be working together the rest of this year.

Dr. **Austen**. We look forward to doing that. Thank you.

[The following was subsequently received:]

RESPONSE TO QUESTIONS ADDRESSED TO W. GERALD AUSTEN, MD, FACS,
AMERICAN COLLEGE OF SURGEONS,
AT THE MARCH 22, 1989 HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE HEARING

REPRESENTATIVE STARK. If expenditure targets are implemented for surgery, a federal entity will have to be made responsible for conducting annual negotiations with the profession. Since Congress does not have the expertise, or the inclination, to do this, the College should work in concert with the Physician Payment Review Commission (PPRC) to determine who should assume this responsibility.

DR. AUSTEN. We have presumed that any physician payment reform legislation would continue to look to the Secretary of Health and Human Services as the responsible Federal official to administer the Medicare program. New responsibilities would be assigned the Secretary under the plan we have in mind.

However, we would also find it entirely appropriate for Congress to obtain independent advice about payment policy issues from an independent body as well. Thus, the PPRC could be given a much greater role than it now has in determining Federal physician payment policy options. Likewise, the Commission or some other body could be authorized to perform certain ministerial functions as well, including negotiations with physician organizations on key payment questions--e.g., the establishment of expenditure targets. We could support any of these approaches.

REPRESENTATIVE STARK. The College should work with PPRC to determine how national expenditure targets should be phased in.

DR. AUSTEN. We have recommended phasing-in payment reform changes in order to minimize disruptions for patients and physicians, and to permit time to develop the administrative machinery to make these new approaches to payment workable. However, some payment reform steps can be taken immediately, and we are prepared to work with you to get payment reform off the ground this year. If some of the modifications in relative values we proposed are acceptable, implementation of a new fee schedule for surgical services could perhaps be accelerated. However, we do believe that some time will be required to develop the infrastructure needed before expenditure targets are applied.

REPRESENTATIVE STARK. Electronic billing is an important component in the Health Care Financing Administration's effort to collect data that Congress needs to make Medicare policy decisions. How can surgeons be encouraged to use electronic billing? Would a "carrot", such as instant credit for billed services, provide sufficient incentive for more surgeons to bill electronically?

DR. AUSTEN. We agree with you that Medicare's current paper-driven claims processes are administratively burdensome and complex for patients and doctors alike. We also believe that payment reform changes can be accompanied by significant improvements in the administration of the Medicare program. Electronic billing, it seems to us, certainly could play a role in this regard. We presume that the Government itself would have to bear most of the costs of installing the equipment, developing the software and maintaining the electronic billing systems used for the Medicare program. Nevertheless, electronic billing certainly may make sense when the volume of Medicare patients served is sufficient to justify such an investment. We would be pleased to discuss these matters in more detail.

REPRESENTATIVE STARK. Questions have been raised about whether Medicare payments are sufficient to cover the costs of rising malpractice insurance premiums, particularly in states that have mandatory assignment laws. As an alternative, would the College be supportive of a Medicare policy that requires beneficiaries to settle their malpractice claims through arbitration? Can the College provide any information on state arbitration programs? How much money could the federal government save?

DR. AUSTEN. We, too, are greatly concerned about the problems with the costs of professional liability insurance. We believe that fundamental reforms in State laws relating to professional liability and the resolution of complaints through means other than tort law would benefit everyone. We would support any steps by the Federal Government to resolve these issues, even if they were only limited in their application to the Medicare program.

Chairman **Stark**. Thanks a lot.

Our next witness will be Dr. Joseph T. Painter, the vice chairman of the board of trustees of the American Medical Association.

STATEMENT OF JOSEPH T. PAINTER, M.D., VICE CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS N. RUBIN, DIRECTOR, DIVISION OF LEGISLATIVE ACTIVITIES, AND MARK J. SEGAL, PH.D., DIRECTOR, DEPARTMENT OF HEALTH CARE FINANCING

Dr. **Painter**. Thank you, Mr. Chairman.

Chairman **Stark**. Welcome, Doctor. Your statement, which we have a copy of here, will appear in the record in its entirety. And please as we have given everyone else the chance to comment on other peoples' testimony, feel free to comment on the previous witnesses' testimony or expand on your own, or enlighten us in any way you chose.

Dr. **Painter**. Thank you, Mr. Chairman, members of the subcommittee. I would like to give you just a brief overview—summarizing the statement which you have.

We support many of the PhysPRC recommendations. We strongly advise against endorsing all of them. At the outset, let me clearly state our position in four key areas.

One, expenditure targets. The PhysPRC's recommendation calling for expenditure targets is a radical departure from the commitment made by Congress in creating Medicare to provide the elderly with all necessary medical care. Their proposal may appear to be a painless way to hold down expenditures, but it must be recognized for what it is, an implicit system to ration health care.

Establishing such a national or regional system of expenditure targets would result, we feel, in many of the same problems evidenced in those Canadian provinces that limit total expenditure for medical and health services. As report in the Canadian press, patients have long waits. In fact, there are reports of death while awaiting definitive surgery. There are too few personnel. There are reports that individual elderly patients are not attended to. And there is a lack of technology. For example, only 11 hospitals are capable of performing open-heart surgery in Canada.

Based on those recent results and a study which AMA has that is ongoing to review the Canadian experience, we do not believe that Congress should experiment on our elderly population with this type of proposal. We urge you to reject this approach.

Rather than ration care, efforts to improve quality and outcome assessment to eliminate those inappropriate services should be accelerated. This can best be achieved through funding of research and the quality assessment so that our physicians can be provided with clinically sound guidance as to what is appropriate and integrate that into their services. We agree with the PhysPRC's recommendation for continued funding in this area.

One potential—and we think very workable—solution is the development of practice parameters. The AMA is taking a lead role in this area and now has a contract with RAND Corp. to develop such parameters. Clearly we believe that this type of approach is far more effective in reducing inappropriate care than will expenditure targets.

The AMA has long supported the development of an indemnity fee schedule based on a resource-based relative value scale. We agree with the Commission that the Harvard study, if corrected and improved as discussed in our report, provides the basis for a Medicare fee schedule.

The AMA supports a transition over a number of years to move from the current payment method to the new fee schedule using an RBRVS. Given the available data, we support a blended transition to arrive at an RVS fee schedule and avoid any disruption that may develop from a precipitous conversion to a new system.

That approach also would allow for monitoring of access of other issues for early correction if needed. In updating this schedule, we believe the medical community needs to be directly involved.

We appreciate the mention of AMA's activity and statement in the PhysPRC report. However, to have an indemnity schedule that will work, we need to make sure that the involvement of medicine and of the AMA is one of substantial involvement. As plans for implementation progress, we will be eager to discuss this important matter in greater detail with this committee and with the Commission.

On the issue of mandated assignment, the AMA supports the Commission's decision not to recommend mandated assignment under the Medicare program. It is important to note that physician balance billing and other beneficiary expense responsibility do not represent a financial barrier to needed care. The record also clearly demonstrates that physicians do respond to their patient's economic circumstances and accept assignment in a vast majority of the time, in 1988 a record rate of 78 percent.

Policy approaches that restrict or eliminate physicians' ability to establish fees are not warranted by this evidence. When one studies the distribution of balance bills and amount of actual individual bills, as the PhysPRC has done, it becomes clear that there simply is not an adequate justification for mandating assignment or imposing other stringent charge restrictions for all Medicare beneficiaries.

The AMA also opposes the Commission's recommendation to control physicians' fees through a continuation of a MAAC program. Controls on physician fees should not be imposed while the rest of the economy is unregulated. Such fee controls will distort the payment system in a manner similar to mandatory assignment.

It also must be realized that limits on balance bills will pose a financial risk to the Medicare program. Studies on the effects of cost sharing by the RAND Corp. and by the CBO indicate that elimination of balance billing could greatly increase Medicare expenditures. And you have as an attachment a statement by Professor Baumol and 11 other economists that bears this out as well.

In conclusion Mr. Chairman, the Commission has done a great deal of good work in the last year and we commend them for their activities. Health care in this Nation, however, is approaching a crossroad. And the choice of which road we pursue will fashion our health care system into the 21st century. We urge caution so that the decisions you make now do not take us down the wrong road, a road where Americans have to line up and wait for essential care as seen in the expenditure target provinces of Canada or a road that denies services to citizens based on age as seen in Great Britain.

The choices you face are important ones, and we urge you to follow the direction that will assure that the physicians of this country can continue our ability to care for a nation's elderly and disabled.

Thank you.

[The statement of Dr. Painter follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Presented by

Joseph T. Painter, MD

RE: Physician Payment Review Commission
Recommendations for 1989

March 21, 1989

Mr. Chairman and Members of the Subcommittee:

My name is Joseph Painter, MD. I am a physician in the practice of Internal Medicine at the M.D. Anderson Cancer Center in Houston, Texas, and I am the Vice Chairman of the Board of Trustees of the American Medical Association. With me today is Ross N. Rubin, Director of the AMA's Division of Legislative Activities, and Mark J. Segal, PhD, Director of the AMA's Department of Health Care Financing.

The AMA appreciates this opportunity to discuss the recommendations adopted by the Physician Payment Review Commission (PPRC) at its meeting of March 9-10, 1989. Since the Commission's full report is not expected to be available until late April, our testimony today will focus on the PPRC recommendations as we currently understand them. We will be conducting a detailed review of the Commission's 1989 report when it becomes available, and we will provide this Committee with our additional views at that time.

Mr. Chairman, the press release announcing this hearing indicates that the major issues to be addressed are: rapid increases in program costs, high out-of-pocket costs for the elderly, and significant inequities in payment allowances. As indicated in the PPRC's recent testimony to the Senate Finance Committee, the Commission has recommendations that address each of these matters. While we support many of these recommendations and we certainly believe that this proposal merits close review, we strongly advise against endorsing all of the PPRC recommendations. In your analysis of the PPRC recommendations, we urge you to consider fully our views and activities in the following four major areas: volume control through expenditure targets; mandated assignment; fee schedule issues; and quality and outcome assessment.

As a prelude to our more detailed analysis on these important matters, I will clearly state our position:

- Expenditure Targets - No matter how this proposal is couched, the bottom line is that it is nothing more than a system of implicit rationing of health care to elderly and disabled Americans. The AMA vigorously opposes the concept of expenditure targets.

- Quality and Outcome Assessment - The AMA is taking a lead role in the development of medical practice parameters.We support the Commission's recommendation for increased funding for research into the quality of medical care and outcomes assessment.

- Indemnity Payment Schedule - The AMA strongly supports the development of an indemnity payment schedule for Medicare, using a resource based relative value schedule (RBRVS).

- Medicare Assignment - Given the promise of an indemnity payment schedule to exert stronger market controls on balance billing, and especially in light of the prevalence of claim-by-claim assignment, the AMA continues to oppose proposals to mandate assignment under Medicare to all enrollees, rich or poor.

EXPENDITURE TARGETS

The Commission's recommendation calling for Medicare expenditure targets constitutes a radical departure from our nation's commitment in creating the Medicare program to provide the elderly with all necessary medical and other acute health care. It will replace that commitment with an implicit system of economic incentives to withhold services to meet the expenditure target. In effect, it calls upon physicians to make the rationing decisions for society on a case-by-case, encounter-by-encounter basis. The PPRC recommendation may appear to be a painless way to hold the line on program expenditures, but the bottom line of a decision to impose expenditure targets is the creation of an implicit system to ration health care. A national target, tied arbitrarily to a formula that depends heavily upon "a decision concerning the appropriate rate of increase in volume of services per enrollee" rather than actual health care needs, provides the starkest possible proof of this point.

In addition to our view that rationing is not an acceptable direction to reduce Medicare expenditures, the American people do not want rationing of health care for the elderly and disabled. Public opinion surveys consistently find that the American people want to cover the health care needs of these populations:

- In response to a 1986 poll conducted for NBC News and the Wall Street Journal, when asked: "To help reduce the federal budget deficit, would you favor reduced benefits for Medicare or not?... 86% answered that they opposed reduced Medicare spending.

- In response to a 1987 poll conducted for ABC News/Washington Post, when asked: "Should spending for (the Medicare program which helps reduce health care costs for the elderly) be increased, decreased or left about the same?"...only 3% called for decreased spending, 22% called for spending to stay the same, and 74% called for increased spending.

- In response to a 1988 poll conducted for NBC News/Wall Street Journal, when asked: "Do you want to see the federal government spend more or less money ...to provide health care for the elderly?"...only 5% called for less spending, and 83% called for more spending to meet the health care needs of the elderly.

Establishing a nationwide or regional system of expenditure targets eventually would devolve into a system that would mirror many of the same problems evidenced in those Canadian provinces (British Columbia, Alberta and Quebec) that limit total expenditures for medical and health services. With their experience as a model for what could happen in our country, there is mounting evidence that limiting program benefits through expenditure targets will result in medically unacceptable results.

As recently reported in the Canadian press, their health system is starting to deteriorate and rationing is now being openly discussed. According to the Canadian weekly newsmagazine Maclean's (February 13, 1989) patients have died after long waits for needed surgery and elderly patients in Montreal hospitals are being kept in diapers because nurses do not have time to help them go to a bathroom. Other examples from these provinces present a telling story:

- The wait in Vancouver for psychiatric, neurosurgical or routine orthopedic consultation is 1 - 3 months, 6 - 9 months for cataract extraction, 2 - 4 years for corneal transplantation, and 6 - 18 months for admission to a long term placement bed.
- Many waiting lists in the province of Quebec for angiograms are six months long.
- The wait in the province of Quebec for coronary artery bypass surgery is 8 - 9 months.
- Montreal and Vancouver emergency departments often have no capacity to handle new patients.
- In all of Canada, there are only 11 hospitals that are capable of performing open heart surgery (793 in the U.S.), 14 hospitals capable of performing organ transplants (319 in the U.S.), and only 12 hospitals have magnetic resonance imaging (MRI) equipment (there are no MRI facilities outside of hospitals in Canada). [Canadian figures are from 1988 and U.S. figures are from 1987.]

Based on the Canadian experience, we do not believe that Congress should experiment on our elderly population with this type of proposal. Such a system is unprecedented in the United States and holds very real risks for our elderly and disabled patients. In the PPRC's testimony before the Senate Finance Committee, they recommended that target rates of increase for the first few years of using such targets "not depart substantially from baseline rates of increase." We applaud this prudent recommendation by the Commission, and we believe that it only proves our point regarding the substantial potential risks that expenditure targets pose for Medicare beneficiaries. We urge you to reject this approach.

We also believe that concern about the continued growth in part B are overstated. Insufficient consideration has been given to some of the very real factors that have led to this increase --including the shift of services from inside hospitals to hospital outpatient departments (See the attached chart, Appendix I, which demonstrates where the greatest part of Part B growth has occurred.) caused by both the hospital prospective payment system (PPS) and the continued evolution of technology that has allowed many more and highly complex procedures to be done safely on an outpatient rather than an inpatient basis.

Recent policy debates regarding the volume and appropriateness of care provided to Medicare beneficiaries have increasingly reflected a perception that there is a broad "volume problem," and suspect physician behavior often is alluded to as a primary cause of this problem. As a result of this perception, there has been growing interest in complex regulatory policies to achieve budget savings through controlling volume growth and reducing levels of unnecessary care. Although the AMA fully supports the elimination of unnecessary care --and we only wish that all of the needed savings could be generated by such a simple solution-- the truth of the matter is that physicians are not causing vast unnecessary program expenditures. The major factors that have contributed to program growth include:

- Improved techniques and technology that make consumption of medical care easier, safer, and more accessible;

- Patients being provided more and better information about the benefits of medical care, especially preventive services and procedures; and
- the cost-sharing provisions of Part B have eroded, resulting in increased demand for medical care.

(A detailed analysis on this issue is attached to this statement as Appendix II.)

QUALITY AND OUTCOME ASSESSMENT

Rather than ration care, efforts to improve quality and outcome assessment to eliminate unnecessary or inappropriate services should be accelerated. This goal can best be achieved though funding of research into quality assessment so that clinically sound guidance can be provided to physicians to integrate into their practices. We agree with the Commission in its recommendation for increased funding in this area. We believe that the focus of such research should be within the office of the HHS Assistant Secretary for Health. We also support improved utilization review. Such research and information transfer will benefit patients and Medicare itself and enable the program to continue to meet its commitment to the elderly.

The American Medical Association acknowledges that appropriateness of care is directly related to the issue of volume. We believe that review of care, to be successful, must be based on physician-developed appropriateness criteria and on coverage decisions that preserve patient access to quality medical care. When utilization management programs are not run properly, the provision of quality health care to program beneficiaries is compromised. Too often, reviewers with little or no clinical training are given authority to deny claims as "not medically necessary." As we have seen, some carriers actually deny claims on the basis of "screen failure" alone without necessary claims development.

One potential and we think workable solution to help assure the provision of high quality care is the development of practice parameters. The AMA strongly supports the development of clinically relevant parameters that are designed to assure that patients receive appropriate medical care. Through our Office of Quality Assurance and Assessment, the AMA is taking the lead role in clinical appropriateness initiatives. The Association has entered into a landmark agreement with the RAND Corporation to develop practice parameters that will have a major impact on the future practice of medicine. (A copy of this agreement is attached as Appendix III.) The AMA is also working with the national medical specialty societies to refine research methodologies and develop dissemination techniques to provide useful and educational information to practicing physicians. Clearly, medicine does not require punitive expenditure targets to act effectively and responsibly to reduce inappropriate care. We expect results from this project beginning in 1989.

FEE SCHEDULE ISSUES

The AMA has long supported the development of an indemnity payment schedule using a resource based relative value scale (RBRVS). In fact, at one time the AMA sought to develop such a study under contract to the Department of Health and Human Services -- only to be told that such an activity would violate federal anti-trust laws. Since we felt that physician involvement in the development of an RBRVS was absolutely necessary to assure its accuracy and acceptance by the profession, the AMA supported the project undertaken by Professor Hsiao at Harvard University and we acted as a subcontractor to the Harvard team. We have undertaken a detailed review of the Harvard report and have attached that review to our this statement.

We agree with the Commission that the study provides the basis, if corrected and improved as discussed in our paper, for a Medicare payment schedule and we are gratified that the PPRC has agreed with that conclusion. We also are in general agreement with the Commission's specific recommendations on practice costs, recognition of professional liability insurance premium differentials, creation of global surgical packages, specialty differentials, use of the Harvard methodology for extrapolation and cross specialty links, inclusion of all medical specialties within a unified RVS (including radiology and anesthesiology), and the use of multipliers to reflect geographic differences in practice costs.

Initial Conversion Factor

We also believe that in converting to a new fee schedule that the initial conversion factor (used to establish the actual payments) should be established as at least budget neutral with regard to current services projections and should not be used as a means of making arbitrary budget cuts.

Transition

The AMA supports a transition over a number of years to move from the current CPR methodology to a new fee schedule using an RBRVS. Given available data, we have supported a blended transition from CPR to an RBRVS fee schedule as the most promising approach to avoid any disruption that may develop from a precipitous conversion to a new system. It would also allow for monitoring of access and other issues for early correction. We understand that the PPRC has recommended an approach that, although not using an explicit blending method, is consistent with the basic rationale for a blend. We plan to study the Commission's proposal closely, particularly with respect to the potential problems inherent with beginning a transition prior to the completion of a final RBRVS and allowing only two years for the transition.

Updating the Schedule

The AMA believes that, for any fee schedule to work in the future for the benefit of both patients and physicians, the medical community needs to be directly involved. We appreciate the fact that the PPRC has recognized that there is a role for the AMA in this activity. However, for the indemnity payment schedule to be effective well into the future, we believe that such a role needs to be one of substantial involvement. The AMA stands ready, willing and able to provide such a role and we urge the Commission and the Congress to seriously consider the active involvement of physicians in any updating process and the role that the AMA is uniquely qualified to provide to assure physician input and clinical direction. We are eager to discuss this important matter with this Committee and the Commission as legislation is developed to establish the fee schedule.

The Commission has articulated a general position on updating the fee schedule. We are very concerned that their proposal to update the conversion factor through a narrow formula tied to a harsh expenditure target has the potential to provide grossly inadequate conversion factor updates.

MANDATED ASSIGNMENT

The AMA supports the Commission's decision to not recommend mandated assignment under the Medicare program. As you well know, mandated assignment would require physicians to accept the Medicare allowed amount as payment in full regardless of the excellence or unique nature of the services provided or the ability of the patient to pay the physician's regular charge for the service.

Medicare already substantially discounts physicians' fees. The gap between Medicare allowed amounts and physician's regular fees has grown from 10% in 1970 to the current approximate level of 27%. In otherwords, years of budget cuts and regulation have left Medicare paying only 73% of physicians' regular fees. Nevertheless, physician acceptance of assignment has continued to increase to all-time record highs. The fact that close to 80% of charges for physician services are assigned demonstrates that physicians are responsible to their patients' situations.

In any discussion of mandatory assignment, it must be realized that the total a physician may bill a patient between the allowed amount and the maximum allowable actual charge represents only a small percentage of the total out-of-pocket expenses a Medicare beneficiary may experience. HCFA estimates average out-of-pocket costs of about $600 in 1987 per aged beneficiary for Part B services, balance billing amounts accounted for about only 18%; while co-insurance amounts accounted for approximately 32%, deductibles accounted for approximately 12%, and premiums accounted for approximately 38% of patient financial liability. (See attached chart, Appendix IV.)

It is also important to note that physician balance billing and other beneficiary expense responsibilities does not represent a financial barrier to needed care. The data from the PPRC's beneficiary survey report that only 6.4% of respondents did not seek care during the previous year because of the cost, with only 3.1% putting off treatment for a serious condition. Only 0.2% reported being actually denied care for financial reasons (including deductible, co-insurance and balance billing). Although any delay in seeking treatment due to financial considerations is worrisome, these numbers do not suggest that balance bills exert a negative impact on access.

This record clearly demonstrates that physicians do care about their patients' economic circumstances and accept assignment a vast majority of the time. The AMA encourages physicians to take their patients' economic status into account and data show that they do. An Urban Institute study summarized evidence that physicians are more likely to assign claims in low-income areas. The Physician Payment Review Commission's physician survey revealed that patients over age 75 were more likely to have claims assigned, and that claims are more likely to be assigned if the patient lacked supplementary insurance. Another PPRC analysis found that voluntary assignment rates were higher for poor patients than for better-off ones. Consider the following points from the PPRC surveys:

- For individuals with a regular source of care, the PPRC beneficiary survey reported that the voluntary assignment rate (excluding Medicaid) from the patient's regular physician was 56%, and 68% on the last visit with a specialist. The physician survey found that of non-participating physicians, 85% routinely accepted assignment for some of their patients, regardless of the service provided, and that 95% of these physicians consider the patients financial status in this decision.

- When beneficiaries were asked whether they were actually balance billed on their most recent bill, only 17% indicated that they had been, with those over age 85 and those below 200% of the poverty level least likely to have received such a bill.

- A PPRC analysis of 1987 data from eight states found that 3% of patients had annual balance bills exceeding $500, that 52% had no balance billing liability and 30% had balance bills of $50 or less. Even among those patients with more than $5,000 in annual Medicare allowed charges, the majority had $50 or less in balance bills.

Policy approaches that restrict or eliminate physicians' ability to establish their fees are not warranted. When one studies the distribution of balance bills and the actual amount of individual bills, as the PPRC has, it becomes clear that there simply is not a large enough number of persons who are experiencing substantial financial problems from balance bills to justify mandating assignment or imposing stringent charge restriction for all Medicare beneficiaries.

With a Medicare fee schedule, the problems of mandatory assignment would be compounded because such a fee schedule will not reflect differences in quality, amenities and other factors that make up the service. Without the ability to balance bill, there will be no recognition of experience or other special abilities. The remuneration for a physician on his or her first day of practice for a service will be the same as for a highly skilled practitioner with decades of practice and experience.

For many of the same reasons, we oppose the Commission's recommendation to control physicians fees through a continuation of a Maximum Actual Allowable Charge program. Controls on physician fees should not be imposed while the rest of the economy is unregulated. Such fee controls encourage utilization by keeping the price of medical services low to consumers and do not reflect increases in the costs of services that physicians must pay in the uncontrolled market. They will distort the payment system in a manner similar to mandatory assignment. We believe that the MAAC program should be allowed to terminate as Congress intended.

It also must be realized that limits on balance bills will pose a financial risk to the Medicare program. Studies on the effects of cost-sharing by the RAND Corporation and the Congressional Budget Office indicate that elimination of balance billing could greatly increase Medicare expenditures. (Price controls also carry other substantial risks, as pointed out by eleven prominent economists in the attached Appendix V.)

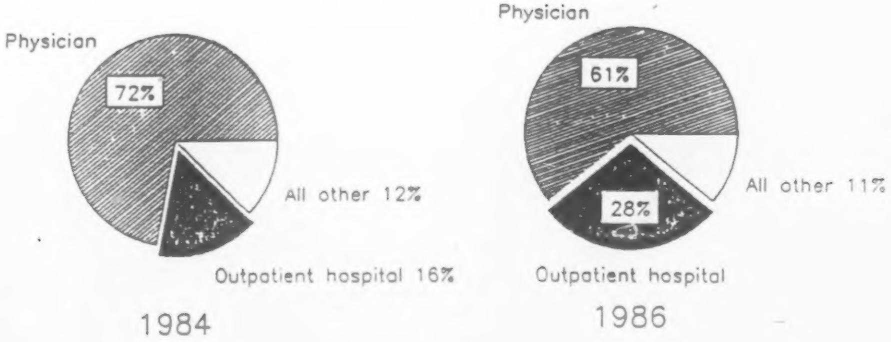
Finally, let me expand on the AMA's efforts in encouraging physicians to consider their patients economic status in the assignment decision. There are currently 34 state medical society voluntary assignment programs either underway or in development. Additionally, there are numerous county programs in effect, many in areas without state programs.

CONCLUSION

Mr. Chairman, the Commission has done a lot in the last year and we commend them. As I have discussed, we agree with many of their recommendations but we also disagree with certain significant proposals. Health care in this nation is approaching a crossroads and the choice of which road we pursue will fashion our health care system for the American people into the 21st century. We urge caution so that the decisions you make now do not take us down the wrong road --a road where Americans have to line up and wait for essential care as seen in the expenditure target provinces of Canada, or a road that denies services to citizens based on age as seen in Great Britain.

The choices you face are important ones, and we urge you to follow the directions that will assure continued our ability to care for our nation's elderly and disabled.

Medicare Part B Spending By Type of Service



MEDICARE PART B EXPENDITURES
ANALYSIS OF GROWTH

INTRODUCTION

Part B of Medicare covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. Disbursements for the Part B program have been the fastest growing non-defense expenditure item in the federal budget in this decade, having increased an average 16.3 percent annually between 1980 and 1987.

Even after inflation in medical care prices has been taken into account, total real disbursements increased at a 7.4 percent average annual rate. Growth in the enrolled Medicare population of 1.9 percent per year accounts for only a small amount of the real growth. The "residual" component of the inflation-adjusted growth that is not explained by beneficiary demographics (5.5 percent) is broadly attributed to increases in "volume" of services per eligible beneficiary and to increased "intensity" of services; i.e. more services per visit.

This report concerns that residual component of outlay growth not due to price inflation or enrollee increase, with special emphasis on the underlying factors responsible for the growth.

COMPONENTS OF PART B OUTLAYS

An accounting adjustment gives a truer picture of cost growth in the Part B program. The usual practice of focusing on cost *per enrollee* overstates the growth in "volume and intensity" when the proportion of enrollees who actually receive services is also growing. Analyzing costs on a per enrollee basis results in confusing the increased number of users as part of the increase in volume per enrollee. According to the General Accounting Office, the number of persons served per 1000 enrollees increased by about 16 percent between 1980 and 1986 (United States General Accounting Office, 1988). This means that growth in real outlays *per service recipient* was 3.0 percent per year.

To better understand the nature of Part B expenditures, it should be kept in mind that:

- physician services are about 60 percent of total Part B allowed charges;
- outpatient hospital department (OPD) services are about 28 percent of total allowed charges; and
- OPD allowed charges grew an average of 30 percent *per year* compared to 13 percent for physician services from 1980 to 1986.

These figures show that outpatient hospital services are a substantial component of the Part B program and contributed more to expenditure increases than physician services in recent years.

A recently completed study of Medicare claims data for five states for the years 1983 through 1985 reached the following conclusions (West *et al*., 1988):

- the major sources of growth in OPD services have been expanding use of OPD surgery and growth in the proportion of eligibles receiving services;
- the expanding use of OPD surgery has resulted in increasing the average allowed charge per service across all services, a common measure of "intensity;" and

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Center for Health Policy Research, American Medical Association, Chicago, Illinois, February, 1989

- **aggregate upcoding explains only a small percentage (4%) of the total increase in Part B allowed charges.**

These findings suggest that the high rate of Part B expenditure growth is primarily confined to hospital outpatient departments, that patient demand has played a significant role, and that the extent of visit and procedure upcoding is far less than has previously been speculated by some analysts.

CAUSES OF INCREASED VOLUME AND INTENSITY

In the past year, research based on new sources of data has begun to replace speculation with documentation on the causes of Part B volume/intensity growth. Research findings fall into four broad areas:

- patient demand;
- technical innovations in outpatient services;
- third-party reimbursement practices; and
- trends in physician supply.

At a recent research conference on Part B volume growth held by the Leonard Davis Institute for Health Economics of the University of Pennsylvania and jointly sponsored by the AMA, there was much agreement among economists that the nature of volume increases evident in this new information is largely a manifestation of increases in patient demand. Demand effects may be broadly separated into two categories: factors that lower price to the patient at the point of service; and non-price factors that increase the amount of services demanded at a given price. Specific research findings include:

- Over the 1980-87 period, legislation raised the Part B deductible only once and increases in premiums were offset to a large extent by patient savings due to the increase in assignment rates (United States General Accounting Office, 1988).

- The 40-month fee freeze of 1983-1987 allowed inflation to erode the real price of services, as has the subsequent MAAC program which has held fee increases below inflation.

- The prevalence of medigap insurance, which typically provides nearly first-dollar coverage, eliminates the constraints on unnecessary use intended to result from Medicare's cost-sharing provisions. As a result, use of Medicare-covered services is higher than it would otherwise be, and most of the costs of the additional services used are paid by Medicare rather than by medigap insurers. The effect of medigap coverage for the typical Medicare-not-Medicaid enrollee is to increase use of both physician and hospital services by about 24 percent. Over 80 percent of aged Medicare enrollees had either medigap insurance or Medicaid coverage in April 1984 (Christensen et al., 1987).

- As a group, the elderly are economically better off than the younger working-age population. In 1986, the average net worth of households with head of households between 65 and 74 years of age was $249,844, compared to $152,391 for households with head of household between 45 an 64, and $56,563 for households with head between 25 and 44. The greater wealth of elderly households would be expected to contribute to a greater demand for health care services.

- Medicare *patients are becoming more aggressive consumers* of medical care and more knowledgeable about the availability and benefits of new technology and procedures. For example, in the four months following President Reagan's cancer surgery in 1985, an estimated 73,000 additional colonoscopies were performed on Medicare patients (McMenamin, 1988).

- The biggest source of increase in approved charges per enrollee in recent years has come from outpatient surgery. The convenience of the outpatient setting significantly *lowers the time price and the psychic cost* to patients, affecting demand similar to a reduction in money price and resulting in a *substantial net increase* in the numbers of such procedures (West *et al*., 1988).

Improvements in the provision of medical services has proceeded apace on several fronts and are making the consumption of medical care easier, safer, and more accessible.

- Clinical innovations in outpatient procedures, as for example in cataract surgeries and endoscopies of the digestive system, have resulted in better products and allowing the physician to do more.

- As a result, *outpatient services are in fact increasing the cost of U. S. health care* in the private as well as public sectors; the Blue Cross and Blue Shield Association found that the number of outpatient visits per thousand people covered jumped 26 percent between 1981 and 1987 and the cost per visit rose 88 percent (Raynor, 1989).

- While the number of visits per person has remained relatively stable, *the length of visits and the number and types of services provided has increased*; specific examples are found in cardiology, thoracic surgery, gastro- enterology, and ophthalmology. (Mitchell *et al*., 1988)

The insurance industry has been responsible for contributing to the shift to outpatient care. Most insurance companies reimburse 100 percent for outpatient care and 80 percent for inpatient care. (Blue Cross and Blue Shield, however, continues to reimburse 80 percent for procedures regardless of where they are performed.) It is natural for patients to seek out the lowest-cost care setting.

The increasing physician supply has resulted not only in increased access but a reduction in prices of physician services as evidenced by the increasing numbers of salaried physicians and increasing physician participation in PPOs and acceptance of discounted fee-for-service payment (Falk and Langwell, 1988).

PART A VERSUS PART B

Proposed federal budgets for both Part A and Part B were cut substantially by the successive budget reconciliation bills enacted during the 1980s. The sum of the budget savings estimated by HCFA for ORA, OBRA-81, TEFRA, DEFRA, COBRA, and OBRA-86 is approximately $18.2 billion for Part A and $13.4 billion for Part B (United States General Accounting Office, 1988). This represents a 6.9 percent reduction in cumulative Part A outlays and a 10.9 percent reduction in cumulative Part B outlays. Thus, relative to the respective program sizes, Part B was cut about one and one-half times more than Part A.

Nevertheless, Part A spending growth in the 1980s has been well below its trend in the 1970s; in contrast, Part B growth has been about the same. The hospital industry has clearly been affected by these Part A cuts, especially in rural areas. The cost-saving effects of the budget acts have been offset by increased utilization of Part B services: 40 percent for OPD services and 15 percent for physician and other Part B services.

CONCLUSION

In many ways, the growth in Part B outlays reflects the success of medicine in making available more and better care to the patient, which in turn has led to increased consumption of medical care:

- Improved techniques are making consumption of medical care easier, safer, and more accessible;

- Patients are being provided more and better information about the benefits of medical care, especially preventive services and procedures; and

- More options are being made available to patients, especially outpatient alternatives to inpatient procedures, affording them wider choice among alternative approaches to managing medical problems which they may choose based on personal, subjective criteria.

At the same time, erosion of the cost-sharing provisions of Part B has also resulted in increased growth in demand:

- Constraining fees by limiting MEI updates, freezing fees, and imposing MAACs has resulted in real growth in allowed charges per service below the rate of inflation;

- Medicare allowed charges are now less than 80 percent of physicians' usual fees; and

- The increasing prevalence of medigap insurance and acceptance of assignment neutralizes cost-sharing requirements.

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APPENDIX III

THE AMA/RAND CLINICAL APPROPRIATENESS INITIATIVE

MEMORANDUM OF AGREEMENT

The American Medical Association and The RAND Corporation have established a cooperative project to improve the health of the American people by developing a process to identify appropriate care and reduce inappropriate care.

This project will:

1. Establish a system to develop appropriateness criteria for selected medical and surgical procedures, diagnoses and conditions.
2. Develop clinically relevant practice guidelines based upon the appropriateness criteria.
3. Disseminate these practice guidelines to assist physicians in clinical decision-making.
4. Evaluate the effectiveness of the project in improving the appropriateness of medical care.

RAND plans to conduct its activities in collaboration with a consortium of academic medical centers. The AMA plans to conduct its activities in collaboration with the national medical specialty societies, state and local medical societies.

Project Plan

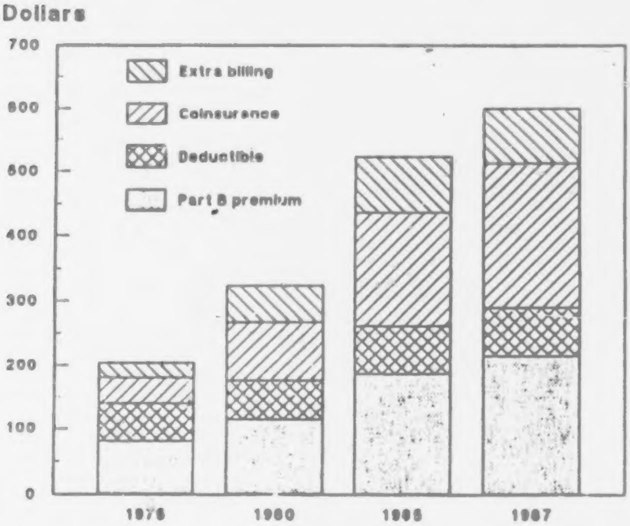
This project will consist of eight major activities:

1. Production of appropriateness criteria for selected medical and surgical procedures, using existing methods.
2. Research to improve the methodology to develop appropriateness criteria for medical and surgical procedures.
3. Research and development regarding diagnosis-based and/or condition-based appropriateness criteria.
4. Production of appropriateness criteria for additional procedures, diagnoses and conditions.
5. Development of practice guidelines based on the appropriateness criteria.
6. Development and testing of methods for dissemination and use of the practice guidelines.
7. Research to evaluate the effectiveness of the project in improving the appropriateness of medical care.
8. Development of a system for maintaining and updating the appropriateness criteria and the practice guidelines.

Institutional Responsibilities

RAND will have responsibility for the research on and development of appropriateness criteria, and the AMA will serve in an advisory capacity on that activity. The AMA will have responsibility for the development and dissemination of practice guidelines based on the appropriateness criteria, and RAND will serve in an advisory capacity on that activity.

AVERAGE ESTIMATED OUT-OF-POCKET COSTS PER AGED ENROLLEE FOR COVERED PART B SERVICES SELECTED YEARS: 1975-1987



SOURCE: HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF THE ACTUARY, DIVISION OF COST ESTIMATES

PRICE CONTROLS—AN INAPPROPRIATE PRESCRIPTION FOR THE RISING COST OF MEDICAL CARE

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March 11, 1988

PRICE CONTROLS—AN INAPPROPRIATE PRESCRIPTION FOR THE RISING COST OF MEDICAL CARE

During the last several decades, the costs of medical services have been rising at a rate persistently more rapid than that of the general price level. This constitutes a real and very urgent problem for the poor in general, and for the elderly poor in particular. But it is a problem which cannot be solved by legislation which seeks to declare its symptoms illegal. Recent proposals undertaking to impose ceilings on the fees that doctors would be permitted to charge their Medicare patients amount to the imposition of a system of price controls. As with most price control measures, these proposals are not only likely to fail to achieve their objective, but are apt to impose a costly burden upon the very persons whose interests they would attempt to protect.

In common with many other personal services, such as education, the performing arts, and a variety of services performed by state and local governments, the costs and prices of medical services have indeed risen at rates substantially higher than the economy's overall rate of inflation. During the 40-year period since 1947, according to U.S. government statistics, in constant dollars, the price of a visit to a doctor's office has risen some 150 percent, the cost of elementary education per pupil per day has risen about 300 percent, and the cost of a day of hospital care has increased approximately 1,750 percent.

No one is sure of the full explanation of these very substantial increases in the cost of medical services. But the rising physician-population ratio, the rising proportion of applicants accepted by medical schools, the increase in the number and membership of organizations such as HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations) whose objective is to hold down medical care costs, and the fact that (in constant dollars) physician incomes have been virtually constant for more than a decade, all suggest that there has been no decline in competitiveness in the health care area such as would account for the pattern of sharp increase in the relative prices of medical services. There is good reason to conclude, rather, that a substantial role was played by the fact that medical care is a personal service which is not amenable to the rates of productivity increase which, for example, have constrained the rates of price increases of manufactured products.

It is important to explore the sources of the price increases experienced by medical services because only after the causes are understood can a rational policy for the containment of the effects of those price increases be formulated. Moreover, to the extent that the price increases are to be attributed to real and largely unavoidable cost increases, rather than to the imperfect competitiveness of the medical care industry, the perils of the price control approach are necessarily exacerbated. If rising prices merely reflect real and unavoidable cost increases, a ceiling in prices will inevitably serve, in the long run, to curtail the supply of medical services in general; and a ceiling on fees for the treatment of the elderly is sure to reduce the quality and quantity of services supplied to this population group. Experience shows that, in the long run, it may even increase the prices this group is required to pay. In sum, such controls under these circumstances would constitute no benefit to the group of persons they are intended to protect.

We strongly urge that price controls for medical services not be adopted precipitously. We believe that careful consideration of the matter will make it clear that price control measures for medical services are to be avoided altogether, and that a serious social problem such as this one merits a more reasoned and more promising approach.

Elizabeth E. Bailey
William J. Baumol
James M. Buchanan
Carl F. Christ
H. E. Frech, III
Lawrence R. Klein
Marc L. Nerlove
Sam Peltzman
James B. Ramsey
Richard L. Schmalensee
Martin Shubik
Alan Walters

Chairman **Stark**. Doctor, you made reference to the Canadian system. How do you deal with the recent surveys that show both the people in our country and the people in Canada seem to prefer that system?

Dr. **Painter**. I think that the way in which the question was phrased in the survey simply did not truly reflect some of the problems that are emerging. What we are beginning see is cracks in the Canadian system——

Chairman **Stark**. Sort of like the AMA study on how many doctors own referral interests, and they only sent it to doctors who had microimaging interests, and they happened to not send it to others—and they only counted the replies where people mailed them back. What you are saying is you think the questions were flawed?

Dr. **Painter**. It would appear from AMA's continuing study now, in developing a report for the AMA, that the types of incidents that we are seeing with on-sight visits in Canada are in fact really occurring.

Chairman **Stark**. How do you—how would you chose between an instance like my district—we probably have—Canada has probably half the infant mortality rate that the United States does, which arguably falls at the feet of organized medicine. In my district it is almost impossible for a young, pregnant teenager to get care in Oakland because the physicians are turning their back on the poor.

What is the difference, whether the elderly wait for open heart surgery in Canada or whether poor kids cannot get treatment in Oakland, California? How would you chose between where we ought to concentrate those efforts? I would like you to answer this question. Your assistant there, if he wants to identify himself and answer that, fine. But I would prefer your opinion. I do not know that that takes any great technical assistance.

Dr. **Painter**. Well, I think the answer is that we want both. We do need to address the issues of the elderly and the care that they have as well as the other—provide the other care as well.

Chairman **Stark**. You mentioned financial barriers to needed care. Are you suggesting that physicians do not create that? Are you suggesting that it is your opinion that Americans—Medicare beneficiaries rarely run into a financial barrier to needed care?

Dr. **Painter**. I think that the assignment rate indicates that physicians are in fact taking into consideration the economic circumstances of the patient.

I think the second point——

Chairman **Stark**. Let me ask you this if I may. You practice—you are an internist?

Dr. **Painter**. Yes.

Chairman **Stark**. Private practice?

Dr. **Painter**. Yes.

Chairman **Stark**. And your office is where?

Dr. **Painter**. I am at M.D. Anderson Hospital in Houston.

Chairman **Stark**. You take appointments from the public—you have an office?

Dr. **Painter**. We are a tertiary cancer hospital, so that we take referrals from physicians who initially see the patients.

Chairman STARK. So they come into a waiting room and—to see you? They have been referred there?

Dr. PAINTER. Sure.

Chairman STARK. What kind of forms do they fill out when they come to your office?

Dr. PAINTER. Forms in the sense of entering into being registered as a patient?

Chairman STARK. Yes.

Dr. PAINTER. Most of that is done by telephone, and most of them are preregistered by getting the phone information, what their name is, who is referring them, and the related information regarding their address, next of kin, and all of that.

Chairman STARK. Do you participate or do you take assignment as 100 percent case, or what do you do in your own practice?

Dr. PAINTER. We take on a selected base the assignment as appropriate.

Chairman STARK. How do you determine the appropriateness of that? Do you have a financial statement that you ask your patients to fill out?

Dr. PAINTER. The financial statement is taken as a part of the registration process. And a judgment is made at that time as to whether or not there would be any additional bill made?

Chairman STARK. Does the physician make that judgment? Do you analyze those financial statements?

Dr. PAINTER. Generally speaking, we talk to the patient and find out their circumstances. Because we operate in a different setting than that average office practitioner, many of those things are done administratively rather than on the basis of——

Chairman STARK. Well then, you have no objection to a nonphysician making that determination, as to whether—as a matter of fact, you might stipulate that most doctors are not competent to read a financial statement and make a credit judgment, are they? They are really not trained to do that?

Dr. PAINTER. The important concept is that as physicians we talk over the problem of payment with each patient individually and arrive at whether we issue a bill at all or whether we in effect take an assignment or do not take——

Chairman STARK. How would you possibly know that, Doctor? Do you have any idea what the average American family—how they break their budget down? What if I said to you the average family of four in your district has a $30,000 median income? Do you have any idea what the average family spends on housing and groceries? Can you tell me? I doubt it.

Dr. PAINTER. No.

Chairman STARK. Of course you cannot. You are not trained——

Dr. PAINTER. I think the way.

Chairman STARK. I mean I am getting at a point here that I hear this from the AMA so often, and there is not one in a thousand doctors in this country who are competent to make a financial decision. Most of them are not very good at managing their own financial affairs. How do you expect them to do what bankers are trained to do or Internal Revenue agents are trained to do? I just do not see where you get that information.

Dr. Painter. Let me indicate what AMA is doing. One, we encouraged our doctors across the country to develop a way of assessing the individual patient's economic circumstances and urge them to take assignment or not bill the patient, depending on their choice, if that person does have significant economic problem.

Number 2 what we have done in addition to that and what is emerging in some 34 States, is to develop a voluntary program at the county and State level working with senior citizen groups where those groups make the determination at some agreed-upon level and issue cards to the individual person who then takes it to the doctor, and that is—of course, provides the judgment——

Chairman Stark. Sort of a symbol of poverty, like a yellow arm band in other societies?

Dr. Painter. This simply allows an objective measure by the senior citizen groups to say this person has insufficient funds and therefore you would take assignment.

Chairman Stark. How do you think just changing the fee schedule is going to limit the aggregate amount that we are spending—does that really make good sense to you? When everything we have seen in the past has indicated where we have cut back on fees—let us take x rays, the number of x rays have gone up. It makes good sense to me, it makes good economic sense, and I cannot blame anyone for doing that. They are in the business to make money.

But how are we going to save any money by just adjusting the fee?

Dr. Painter. Well, we think that by having a more rational system that does reimburse in a fair and equitable manner—and we think the RBRVS does provide that as a framework—that this would——

Chairman Stark. Let us take one of your friends who is, let us say, a radiologist, and he is doing whatever he does every day, and he makes a judgment when you send him a patient that you refer to him that maybe two pictures will do but maybe if the gallbladder is hiding behind the—whatever it hides behind—that he will take pictures, that is pretty much his decision, is it not, how many to take to get you the answer you need?

Dr. Painter. Yes.

Chairman Stark. OK. Well, now, does it not make sense to you that if we suddenly say we are going to drop the price from $30 a picture to $20 a picture that this—he just might, if it is on the margin, say why do I not take a couple of extras because my wife bought a new fur coat, and I—it just seems to me how do we prevent him from taking more on the margin and coming right back and not saving any money?

Dr. Painter. AMA's position, is that we need to develop practice parameters. Where much of the problem has occurred is where there is controversy within the medical profession over what is appropriate. So there may be a wide range of agreement.

Chairman Stark. OK. So now we are back to——

Dr. Painter. So what we want to do is——

Chairman Stark. You want to decide.

Dr. Painter. We want to bring together the experts and develop parameters——

Chairman Stark. Why should——

Dr. PAINTER. And say what is appropriate.

Chairman STARK. Why should we not decide as the guardians of the taxpayers' dollars how much we can afford to spend in the aggregate, and then you guys among yourselves decide how to best do that? Would that not give you a goal to shoot toward? How else is the decision going to get made to lower that overall expenditure or the rate of growth in it unless you all decide the professional decisions?

You heard the surgeons here today. What is wrong with their proposal?

Dr. PAINTER. We think that the value side of it is something which we don't well understand.

Chairman STARK. How about the cap side, the volume side?

Dr. PAINTER. The volume side, we feel the expenditure caps and the rationing parts of that, we would not be able to support.

Chairman STARK. What if the surgeons agree to go with us and do it? Are you going to kick them out of the AMA? I mean, it is a pretty respected group of physicians, I would think.

Dr. PAINTER. What we have done in the whole effort to bring about an RBRVS is to bring in all of the specialty societies and State medical associations. We have kept them informed. We have involved them with the panels, with the Harvard study, and we, in effect, at our annual meeting, and you have a copy of report AA, got unanimous agreement among of the specialty societies and the State associations in support of that effort. So we believe that we have a strong base of support. And that did include the surgical specialties as well.

Chairman STARK. Did the American College of Surgeons vote in favor of this?

Dr. PAINTER. They were not represented but all of there subspecialties were. What we would hope is that we would have one RBRVS which would encompass all specialties and which would then——

Chairman STARK. OK. But then what about one cap for all doctors?

Dr. PAINTER. You are talking about an expenditure target?

Chairman STARK. Yes.

Dr. PAINTER. Well, we disagree with the expenditure cap because, as Dr. Lee was saying, he wants to send a signal, but when I take care of you as a patient and you have a certain complaint, I am going to give you the amount of care I think you need in order to establish a diagnosis and get you on the road to recovery.

I think the individual doctor/patient will certainly be aware of some cap that means anything.

Chairman STARK. And that is as it should be. I think you and I both agree with that. But we don't want to be pestered by your making your decision about worrying whether it is going to fit. I concur with you there.

Dr. PAINTER. We think that the individual physician being involved in a rationing decision would be inappropriate. We also think that you have got in addition to that, as I said, the Canadian experience.

Chairman STARK. Wait a minute. Why is it a rationing. All we are suggesting is that you go back at the end of the year among

yourselves and say, "Guys, we spent too much." It doesn't have to be rationing. You all would say that when you don't get as much money as you want, but you could also reduce your fees, couldn't you, and come to the target?

That doesn't have to deny quality service. That is the AMA's position: if we don't get what we want, we won't treat people. But what I am suggesting the alternative to that is, if you don't meet the cap, we can drop all the fees a little bit. Right? That would get you under the cap, wouldn't it, without rationing services?

Dr. PAINTER. Well, I think the important part of that——

Chairman STARK. No. Could you answer that question? Wouldn't that accomplish the same thing as rationing?

Dr. PAINTER. To reduce fees, yes.

Chairman STARK. It would get you into the cap.

Dr. PAINTER. To reduce fees to meet the cap——

Chairman STARK. Yes.

Dr. PAINTER [continuing]. That would accomplish what your goal would be if you establish a cap.

Chairman STARK. And I am suggesting that is what we should do, and you are suggesting rationing. And I am saying, well that doesn't have to be. We could just have the doctors take a little bit——

Dr. PAINTER. In point of fact we believe that a better way of approaching the problem it is not to establish some cap and then make a number of adjustments, but rather to realistically study and ask Congress to fund the research that is needed to develop those proper appropriate—practice parameters.

Chairman STARK. Doctor, let me ask you this. Around here—I don't know whether studying a patient means let the patient die, but around here studying something means ignoring it. It is the best way. Your lobbyists will tell you, to beat something is to study it to death.

Dr. PAINTER. Well, I think the important thing—if I may interrupt—is the RBRVS. Here you had a study that looked at a system that everybody agrees is not good and needed to be replaced, and as a conjoint study you had the research done, you got a product, everybody is rallying around it, and with certain changes and modification we are all agreeing that here is a way that would provide fair and equitable treatment. This same——

Chairman STARK. Whoa. Whoa. Whoa. Doctor, stop there. We all agree it is a good study to decide how you cut up the pie among doctors. No one in their right mind agrees that there is anything in the RVS, in the Hsiao study, that will save in the aggregate. It is merely a study which will tell people how they—it is a guide to how you divide up the pie. There is nothing in that study anywhere that suggests it will reduce the overall costs to the Medicare system.

Dr. PAINTER. But it does provide a more rational way of approaching reimbursement.

Chairman STARK. We will stipulate to that. Let's put that aside. Now let's deal with reducing that increase in the rate. Fifteen percent a year increase in overall cost is too much. What does the AMA say we should do if we have to do something this year? And we may. That may be dedicated by the President that you put in office. How do we get those costs down?

Dr. **Painter**. Two important points. One is that I think Congress needs to address the issue of the total amount of dollars.

Chairman **Stark**. OK.

Dr. **Painter**. Number 2, Congress needs to look at the array of benefits that they are providing the Medicare patient and decide which ones we can not afford, and then realistically come forward to the——

Chairman **Stark**. You want me to ration?

Dr. **Painter**. If there is to be a rationing decision, it should be a public decision that everyone knows about, including doctors and patients, simply on the basis of we can no longer afford to give everything the patient needs as has been previously the case.

Chairman **Stark**. So what you are suggesting is that the AMA basically wants no part. That is what you referred to as a more disruptive proposal that you would like to restrain in your report. You want no part of anything that limits the aggregate payments. That is basically your testimony, isn't it?

Dr. **Painter**. No. I think what we want is two things. One we think an RBRVS should constitute the basis for payment reform, and we think in concurrence with that if we then study the performance type of activities and couple that with more support for the carriers to do utilization review and tying it in with strengthening of the PRO that those issues alone will begin to ameliorate the rate of increase.

Chairman **Stark**. Well, Doctor, let's assume that we are going to do something this year. I presume the AMA doesn't want to be a party to that because they are going to be off worrying about some study that will take a couple of years to do while the surgeons and the radiologists and others are going to sit down and revise a payment schedule that will have a cap.

Does the AMA want to participate in that or does the AMA want to toddle off in their normal 19th century mind-set and complain? I mean, either they are going to be a part of doing this or they are just going to keep saying no, as I am hearing today. No caps.

Dr. **Painter**. I think we are being constructive in our recommendation. The other part is I invite your attention to appendix 2 in our attachment to the report, which really does a part B analysis. And I think one of the things that would be important to say is that about 60 percent of the increase in part B is attributable to physician charges, and the rapid growing area for that is basically the outpatient surgery element.

About 30-percent growth has occurred in hospital outpatient charges, and the end result of that is then the fastest growing segment of part B charges is related to the movement of care into the outpatient area and the more intense care as our technology is applied.

Now we think that that has been good for patients. It has been good for general costs, although in toto part B then has accelerated. There also has been, of course, an increase in the number of eligibles under the program, and that we think is an important consideration, to recognize the change in pattern of care and the fact that we are giving better care in a different setting, or at least improved care in a different setting.

So we think that these elements, if taken into consideration, do show us very definitely that there are major segments in the part B increase that are related to a change in the pattern of practice.

Chairman STARK. Minority staff has raised a question that I would like to get in the record here. You include a table in Appendix 1 which identifies physician payment as 72 percent of part B in 1984 and 61 percent in 1986. HCFA data indicates that those numbers were 73 percent in 1986 and are projected to be 71 percent in 1989.

Could you at some later date provide for the record the source of your tables and explain the discrepancy between your table and the HCFA data as published in the Ways and Means Committee Green Book?

Dr. PAINTER. Yes. We would be pleased to do it.

Chairman STARK. Thanks.

[The information of Dr. Painter follows:]

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DIVISION OF LEGISLATIVE ACTIVITIES
ROSS N. RUBIN, J.D.
Director
(645-4775)

October 18, 1989

The Honorable Fortney Stark
Chairman of the Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This letter is in response to your request during the Subcommittee hearing on the Physician Payment Review Commission (PPRC) recommendations for 1989 held on March 21, 1989. At that time you requested that the American Medical Association provide you with additional material explaining an apparent discrepancy between AMA data and the Health Care Financing Administration Office of the Actuary's data for Medicare Part B spending for physicians services. More specifically, you requested an explanation as to why there was a difference between AMA data which indicates that physician payment was 72% of Part B in 1984 and 61% in 1986 and the data contained in the Ways and Means Green Book which indicates physician payment was 73% in 1986 and projected to be 71% in 1989. In developing our figures, we used the data published in the Social Security Bulletin. The bulletin is printed by HHS and widely circulated. We presume the figures therein are accurate.

Attachment 1 presents percentages of Part B spending from three sources. Two points can be made concerning this table. First, regardless of which source is used, the share of Part B spending attributed to physicians has declined since 1984. Second, the Social Security Bulletin (SSB) percentages are smaller than those of the Actuary because the SSB definition of a "physician service" is more restrictive than the Actuary's.

A more detailed discussion of Medicare data sources is contained in Attachment 2. We hope this answers your questions concerning the apparent discrepancy in data. If you have further questions, please feel free to contact me.

Sincerely,

Ross N. Rubin

RNR/cac
1616s/41

Attachments

cc: Congressman Gradison

ATTACHMENT 1

Percent of Medicare Part B Expenditures on Physician Services,
By Source and Year

Year	Social Security Bulletin Allowed Charges	Social Security Bulletin Reimbursements	HCFA Actuary
1984	71.9%	73.2%	78.2%
1985	70.0	72.5	75.5
1986	60.8	65.1	73.3
1987	n.a.	n.a.	73.4
1988	n.a.	n.a.	71.7

Sources: Social Security Bulletin, Annual Statistical Supplement, 1987, table 160; HCFA Office of the Actuary, SMI-1 Medicare: Estimated Supplementary Medical Insurance Disbursements, unpublished report, February 21, 1989.

n.a. = not available.

Attachment 2

Medicare Part B Expenditure Data

This report discusses sources of data on Medicare program expenditures. Two annual and two monthly sources are considered. Comparisons between the two annual sources are made on the basis of definitions of components of spending. In addition, time trends are presented and compared.

ANNUAL DATA

The Health Care Financing Administration's (HCFA) Office of the Actuary maintains records on annual spending under Medicare. Occasionally, tabulations are reported in such publications as the "Green Book" (Committee on Ways and Means, 1989) and the SMI Trust Fund Report (Board of Trustees, 1989). Data reported in an unpublished internal HCFA tabulation (Office of the Actuary, 1989) provide greater detail than published HCFA data. For this reason, this source is used for HCFA data included in this appendix.

A second source of published data on Part B spending is the Social Security Bulletin (SSB). Despite the fact that they appear in a Social Security Administration publication, the SSB data are obtained directly from HCFA.

For a given year, one would suppose that the spending figures from the Actuary and the SSB would be identical. As the first two columns of Table 1 show, this was not precisely true for any year between 1980 and 1986. The reasons for the discrepancy are technical and will only be highlighted here.[1] First, the two sources reflect the counting of a dollar as spent at different points in the claim cycle. The Actuary data are for the year in which a carrier reports a check as being written, whereas the SSB data assign spending to the year in which the claim is finally and officially recorded in the central files. This would cause the SSB data to be lower because they lag in time in a growing series.[2]

Second, the SSB data are compiled by HCFA from contractor payments to providers, whereas the Actuary data reflect funds drawn from the Treasury. The SSB figures are necessarily a little lower because not all contractors provide bills to HCFA.[3]

Components of Spending

The most dramatic differences between SSB and Actuary data are due to the way each source disaggregates the data. The way the two sources differ is shown in Table 2.

With respect to "physicians", the Actuary includes payments to suppliers in addition to practitioners. The SSB includes only MDs and other health care practitioners. Hence, physician expenditures will necessarily be higher in the Actuary data because of the more comprehensive definition. Similarly, outpatient figures will tend to be higher in the Actuary data because they include services of ambulatory surgery centers and other free-standing outpatient health service centers, in addition to outpatient hospital services, whereas the SSB data include only outpatient hospital services.

The remaining columns of Table 1 present expenditure data for physician services, outpatient services, and all other services as defined by each source. The lower half of the table contains the shares of the total accounted for by each component. For physician services, the SSB shares are lower than those of the Actuary, as expected. Another interesting way to look at the data is over time. Figure 1 graphically displays the Actuary and SSB physician shares from 1980 to 1986. The SSB shares are fairly stable until 1986, whereas the Actuary shares gradually decline after 1983. The SSB share drops dramatically in 1986. The most likely explanation is that the spending figures for that year are incomplete.[4] Figure 2 presents share-of-total trend lines for outpatient services. The sharp upturn in SSB in 1986 is probably due to the same type incomplete data problem as for physician services.

Comparison of the Two Sources

Each of the two data sources discussed here has strengths and weaknesses. The SSB data have clean definitions of physician and outpatient hospital services and are published in a widely distributed medium. Unfortunately, accurate and complete figures for important components lag behind the current year by about three years; perhaps this is the reason that these data are not used frequently in policy circles. The Actuary data are much more up-to-date and tend to be used by persons involved in the policy-making process. However, certain components are so broadly defined as to obscure true developments in important types of service.

MONTHLY DATA

Two sources of monthly data on Part B expenditures are available. The Monthly Treasury Statement of Receipts and Outlays of the United States Government reports outlays for benefit payments from the SMI ("Part B") Trust Fund. A second source is reports submitted to HCFA from the carriers that process Part B claims.

The Treasury data on outlays are rather inclusive. They include payments for non-physician services under Part B (e.g., outpatient and independent lab). They may also include payments for health insurance for the aged, but whether and how much this occurs is not discernible from the published reports. Table 3 is a copy of a page from the Monthly Treasury Statement for July 1989, showing benefit payment outlays for the SMI trust fund.

The data submitted to HCFA by the 56 carriers is aggregated and used mainly for internal purposes at HCFA. Nevertheless, these data have been obtained by AMA via telephone. According to HCFA staff, the data represent "cash out the door," and are net of claims denials, uncashed benefit checks, and capitation payments for beneficiaries enrolled in prepaid medical plans. It is important to note that the HCFA data exclude Part B payment data from the fiscal intermediaries that process claims for outpatient and home health services. Hence, the HCFA carrier data are a closer approximation to physician expenditures than are the Treasury data for all of Part B. The information is not available for an exact accounting of all differences between Treasury and carrier data.

Figure 3 displays monthly Treasury and HCFA carrier data since January 1988. The Treasury data are higher for every month--by an average of $790 million. Nevertheless, the two series are highly correlated (r=+0.84), tending tend to move up or down together from one month to the next. The Treasury data are slightly more variable from month to month with a mean percent change (either up or down) of 14.2%, while the mean percent change for the carrier data is 11.1%.

These measures of close proximity suggest that either series may be used for measuring monthly percentage changes in physician service expenditures. The carrier data are preferred, when available, because they include fewer non-physician services by definition. Similarities notwithstanding, month-to-month variations in both series are high and changes are about equally likely to be down as up. This suggests that virtually nothing about longer term trends may be inferred from month-to-month changes. Instead, annual data for several years should be used.

Table 1

Medicare Part B Benefit Payments According to Two Sources, By Selected Type-of-service Components, 1980-1986

	Total		Physicians		Outpatient		All Other*	
Year	SSB	ACT	SSB	ACT	SSB	ACT	SSB	ACT
	Dollars (billions)							
1980	10.3	10.6	7.6	8.2	1.4	1.9	1.3	0.5
1981	12.2	13.1	8.9	10.1	1.7	2.4	1.5	0.6
1982	15.1	15.5	11.1	11.9	2.2	3.3	1.8	0.5
1983	17.1	18.1	12.4	14.1	2.6	3.4	2.1	0.7
1984	17.9	19.7	13.1	15.4	2.7	3.5	2.1	0.8
1985	20.4	22.9	14.8	17.3	3.1	4.3	2.5	1.3
1986	24.9	26.2	16.2	19.2	5.6	5.1	3.1	1.9
1987	na	30.8	na	22.6	na	5.9	na	2.3
	Share of Total							
1980	1.00	1.00	0.74	0.77	0.14	0.18	0.13	0.05
1981	1.00	1.00	0.73	0.77	0.14	0.18	0.12	0.05
1982	1.00	1.00	0.74	0.77	0.15	0.21	0.12	0.03
1983	1.00	1.00	0.73	0.78	0.15	0.19	0.12	0.04
1984	1.00	1.00	0.73	0.78	0.15	0.18	0.12	0.04
1985	1.00	1.00	0.73	0.76	0.15	0.19	0.12	0.06
1986	1.00	1.00	0.65	0.73	0.22	0.19	0.12	0.07
1987	na	1.00	na	0.73	na	0.19	na	0.07
	Dollar Change From Previous Year (Percent)							
1980	--	--	--	--	--	--	--	--
1981	18.4	23.6	17.1	23.2	21.4	26.3	15.4	20.0
1982	23.8	18.3	24.7	17.8	29.4	37.5	20.0	-16.7
1983	13.2	16.8	11.7	18.5	18.2	3.0	16.7	40.0
1984	4.7	8.8	5.6	9.2	3.8	2.9	0.0	14.3
1985	14.0	16.2	13.0	12.3	14.8	22.9	19.0	62.5
1986	22.1	14.4	9.5	11.0	80.6	18.6	24.0	46.2
1987	na	17.6	na	17.7	na	15.7	na	21.1

Source: SSB data are from the Social Security Bulletin, 1988 Annual Statistical Supplement, Table 7.B9; data are for year recorded. ACT data are from HCFA Office of the Actuary, SMI-1 Medicare: Estimated Supplementary Medical Insurance Disbursements, February 21, 1989; data are on a cash basis.

*SSB: Includes home health, independent lab, and "other" services. ACT: Includes home health, group practice prepayment plan, and independent lab.

na - not available.

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Table 2

Comparison of Social Security Bulletin and Office of the Actuary Concepts of Medicare Part B Services

	Social Security Bulletin	Office of the Actuary
Time period	. Period bill or payment record recorded in HCFA central office files	. Period cash withdrawn from the treasury account.
Source of data:		1/
Physician	. Payment records 2/	. Payment records 2/
Outpatient	. UNIBILL	. UNIBILL
Home health	. UNIBILL	. UNIBILL
Independent lab	. Payment records	. Payment records
GPPP	NA	. Capitated financial system
Other	. UNIBILL's and payment records 2/	NA
Type of service		
Components:	. Physician	. Physician
	. Outpatient	. Outpatient
	. Home health	. Home health
	. Independent lab	. Independent lab
	. All other	. GPPP
Definitions:		
. Physician	. MD	. MD
	. DO	. DO
	. Oral surgeon	. Oral surgeon
	. Chiropractor	. Chiropractor
	. Optometrist	. Optometrist
	. Podiatrist	. Podiatrist
	. Clinics composed of physicians from two or more specialties 4/	. Clinics composed of physicians from two or more specialties 4/
		. Orthotist or prosthotist medical suppliers
		. Ambulance service suppliers
		. Independently-billing psychologist, X-ray supplier, audiologist, & physical therapist
		. Drug or department stores
		. Health or welfare agencies
		. Facility component for ambulatory surgical centers
. Physician service 2/	. Medical services . Surgical services plus assistance at surgery	. Medical and surgical care, lab, X-ray, and ambulance services, physical and occupational therapy, prosthotics and durable medical equipment

(Continued)

. GPPP 3/	NA	. Reasonable-cost basis or risk-basis payments to health maintenance organizations (HMO), competitive medical plans (CMP), and health care prepayment plans (HCPP).
. Outpatient	. Outpatient hospital	. All outpatient including: 5/ outpatient hospital rural health clinics free-standing renal dialysis centers SNF & hospital inpatient services comprehensive health centers comprehensive outpatient rehab. facility hospice care blood
. Other	. Orthotist or prosthotist medical suppliers . Ambulance service suppliers . Independently-billing psychologist, X-ray supplier, audiologist, & physical therapist . Drug or department stores . Health or welfare agencies . Facility component for ambulatory surgical centers . GPPP non-physician services including: diagnostic X-ray and lab, physical and occupational therapy, and other medical care services . Outpatient billings for: rural health clinics free-standing renal dialysis centers SNF & hospital inpatient services comprehensive health centers comprehensive outpatient rehab. facility hospice care blood	NA

1/ Distribution of total benefit payments by type of service is estimated by Medicare actuaries using billing and other data.

2/ Payment record type and place of service categories are determined by the largest single charge on the bill.

3/ Group practice prepayment plans: HMO's and CMP's must provide all covered Part A and Part B services. The HMO or CMP contracts with Medicare to be paid on either a reasonable-cost basis or on a risk-basis. HCPP's provide Part B covered services and are paid on a reasonable-cost basis.

4/ Charges must be uniform for a procedure regardless of the physician in the group performing the procedure. Medicare is billed by the group and the individual physician's specialty is unknown. Medicare reimburses for Part B services on a reasonable-cost basis.

5/ Includes only non-physician services.

Table 3

Outlays of the U.S. Government, July 1989 and Other Periods—Continued

[$ millions]

Classification	This Month			Current Fiscal Year to Date			Prior Fiscal Year to Date		
	Gross Outlays	Applicable Receipts	Outlays	Gross Outlays	Applicable Receipts	Outlays	Gross Outlays	Applicable Receipts	Outlays
Department of Health and Human Services, Except Social Security:									
Public Health Service:									
Food and Drug Administration	37	(**)	37	418	2	416	384	2	382
Health Resources and Services Administration:									
Public enterprise funds	7	......	7	14	......	14	26	......	26
Health resources and services	157	......	157	1,195	......	1,195	1,274	......	1,274
Indian Health Service	65	......	65	858	......	858	773	......	773
Centers for Disease Control	69	......	69	671	......	671	498	......	498
National Institutes of Health:									
Cancer Research	141	......	141	1,345	......	1,345	1,171	......	1,171
Heart, Lung, and Blood Research	79	......	79	899	......	899	807	......	807
Diabetes, Digestive and Kidney Diseases	45	......	45	492	......	492	436	......	436
Neurological Disorders and Stroke	45	......	45	479	......	479	422	......	422
Allergy and Infectious Diseases	55	......	55	576	......	576	454	......	454
General Medical Sciences	42	......	42	582	......	582	475	......	475
Child Health and Human Development	38	......	38	353	......	353	306	......	306
Other research institutes	71	......	71	764	......	764	741	......	741
Research resources	42	......	42	328	......	328	283	......	283
Other	−24	......	−24	131	......	131	126	......	126
Total—National Institutes of Health	535	......	535	5,949	......	5,949	5,222	......	5,222
Alcohol, Drug Abuse, and Mental Health Administration	139	......	139	1,142	......	1,142	1,067	......	1,067
Office of Assistant Secretary for Health	18	......	18	183	......	183	205	......	205
Total—Public Health Service	1,026	(**)	1,026	10,431	2	10,429	9,450	2	9,447
Health Care Financing Administration:									
Grants to States for Medicaid	2,926	......	2,926	28,383	......	28,383	24,868	......	24,868
Payments to health care trust funds	2,574	......	2,574	27,386	......	27,386	23,028	......	23,028
Other	−2	......	−2	71	(**)	72	55	......	55
Federal hospital insurance trust fund:									
Benefit payments	4,456	......	4,456	47,129	......	47,129	42,761	......	42,761
Administrative expenses and construction	92	......	92	628	......	628	524	......	524
Interest on normalized tax transfers	......	......	......	......	......	......	......	......	......
Total—FHI trust fund	4,548	......	4,548	47,757	......	47,757	43,285	......	43,285
Federal supplementary medical insurance trust fund:									
Benefit payments	3,085	......	3,085	29,916	......	29,916	27,364	......	27,364
Administrative expenses and construction	94	......	94	1,161	......	1,161	1,094	......	1,094
Total—FSMI trust fund	3,179	......	3,179	31,076	......	31,076	28,457	......	28,457
Federal supplemental medical insurance catastrophic coverage trust fund	10	......	10	71	......	71	......	......	......
Total—Health Care Financing Administration	13,234	......	13,234	134,745	(**)	134,746	119,694	......	119,694
Social Security Administration:									
Payments to social security trust funds	849	......	849	5,933	......	5,933	5,417	......	5,417
Special benefits for disabled coal miners	74	......	74	746	......	746	769	......	769
Supplemental security income program	−28	......	−28	9,473	......	9,473	9,606	......	9,606
Total—Social Security Administration	895	......	895	16,152	......	16,152	15,791	......	15,791
Family Support Administration:									
Program administration	6	......	6	64	......	64	60	......	60
Family support payments to States	910	......	910	9,361	......	9,361	9,041	......	9,041
Low income home energy assistance	45	......	45	1,345	......	1,345	1,521	......	1,521
Refugee and entrant assistance	15	......	15	290	......	290	258	......	258
Community services	34	......	34	330	......	330	342	......	342
Interim assistance to States for legalization	18	......	18	226	......	226	(**)	......	(**)
Other	7	......	7	67	......	67	73	......	73
Total—Family Support Administration	1,035	......	1,035	11,683	......	11,683	11,297	......	11,297
Human Development Services:									
Social services	206	......	206	2,224	......	2,224	2,106	......	2,106
Human development services	200	......	200	2,279	......	2,279	1,666	......	1,666
Payments to states for foster care and adoption assistance	63	......	63	879	......	879	854	......	854
Total—Human Development Services	469	......	469	5,302	......	5,302	4,706	......	4,706
Departmental management	2	......	2	115	......	115	168	......	168
Proprietary receipts from the public	......	1,013	−1,013	......	9,525	−9,525	......	7,222	−7,222
Intrabudgetary transactions:									
Payments for health insurance for the aged:									
Federal hospital insurance trust fund	......	......	......	......	......	......	......	......	......
Federal supplementary medical insurance trust fund	−2,574	......	−2,574	−26,372	......	−26,372	−22,071	......	−22,071
Payments for tax and other credits:									
Federal hospital insurance trust fund	......	......	......	−1,015	......	−1,015	−1,037	......	−1,037
Other	......	......	......	......	......	......	......	......	......
Total—Department of Health and Human Services, Except Social Security	14,088	1,013	13,075	151,122	9,528	141,595	137,996	7,224	130,772

Notes

1. A more detailed discussion is contained in a separate report (Center for Health Policy Research, 1989).

2. To illustrate, suppose the SSB data lag the Actuary data by one year. Then the SSB data for year t would be identical to the Actuary data for t-1 and, hence, necessarily less than the Actuary data for t, as long as the data always grow over time.

3. Actuary data include risk-basis payments and prepayment amounts to Group Practice Prepayment Plan providers, whereas SSB data do not.

4. Physician and supplier service claims are processed through carriers. Beneficiaries may hold claims for up to fifteen months. Outpatient, home health, and independent lab services are submitted by providers, usually without delay. For this reason, shares of total spending for the last year reported (1986 as of this writing) may be underrepresented for physician services and overrepresented for outpatient services.

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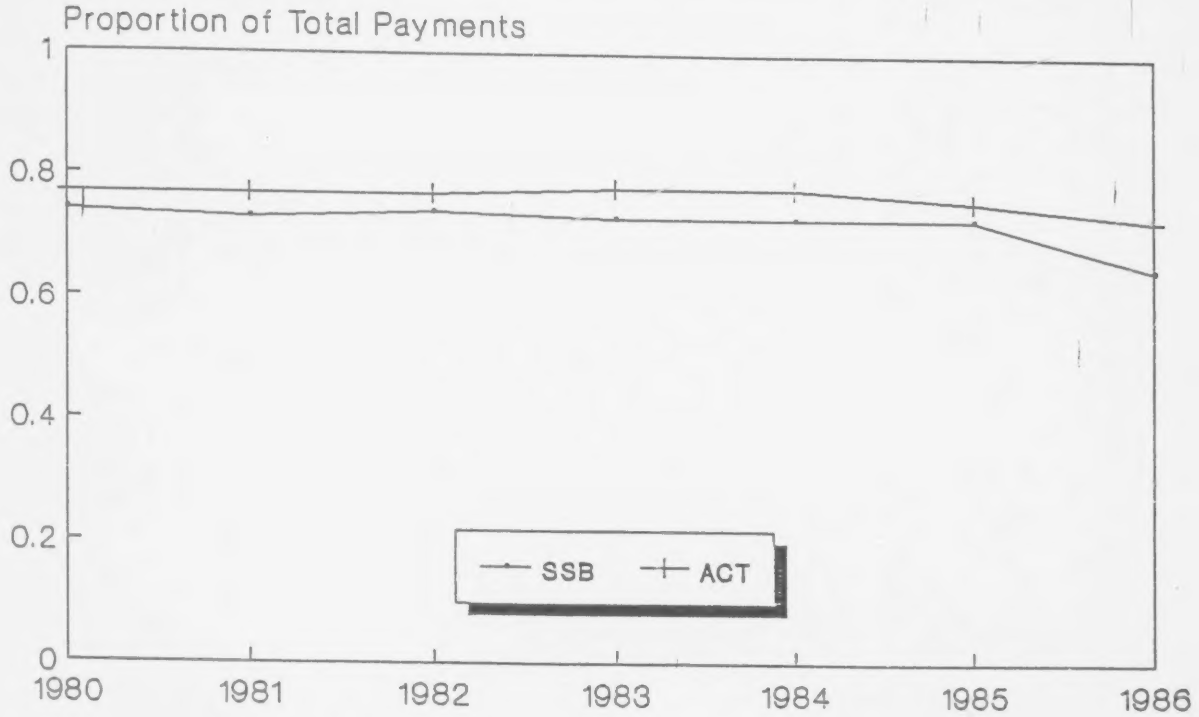
Committee on Ways and Means. U. S. House of Representatives. Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means. Washington, D.C.: U. S. Government Printing Office, March 15, 1989.

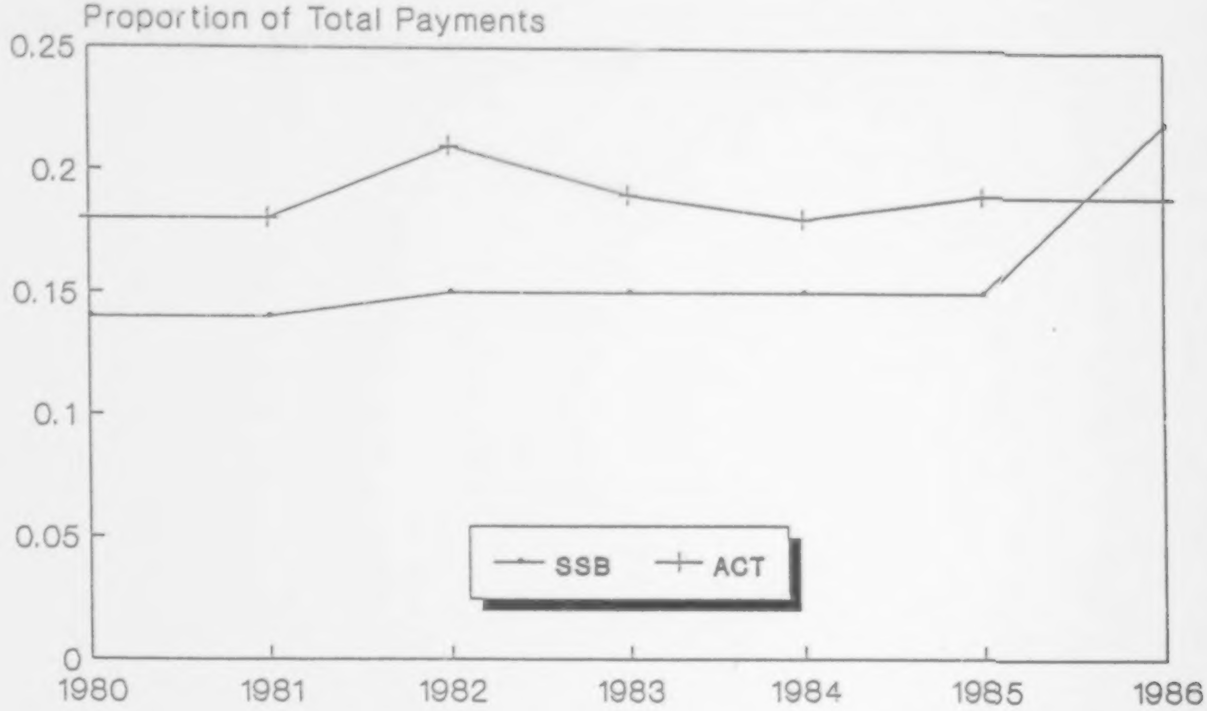
Office of the Actuary. Health Care Financing Administration. SMI-1 Medicare: Estimated Supplementary Medical Insurance Disbursements. Unpublished report, February 21, 1989.

Figure 1
Physician Services Payment Shares



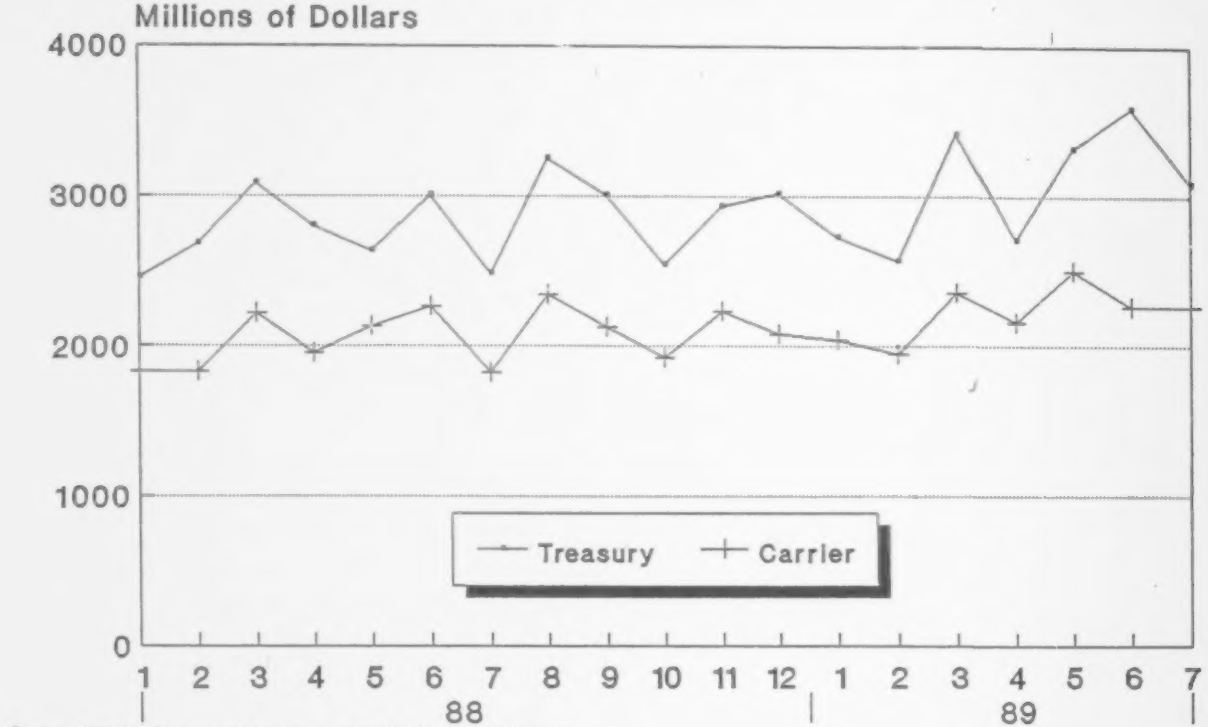
See text for sources and definitions
8/18/89

Figure 2
Outpatient Services Payment Shares



See text for sources and definitions
8/18/89

Figure 3
Treasury & Carrier Monthly Part B Data



See text for sources and definitions
9/20/89

Chairman **Stark**. Well, Doctor, you don't seem to be addressing Congress' problem, and I guess that is a 15 percent compound growth rate, approximately a 15 percent compound increase in physicians' net income after expenses, a 50 percent greater expenditure of our gross national product than other nations which have a better record of providing health care to their citizens than does the United States as measured by almost every statistic available, and some great pressure to reduce the deficit.

Now the relative value scale, which the AMA contributed to bringing some consensus to, is a useful tool when you ration whether it is care or dollars. I ~~prefer~~ to ration the dollars to physicians who are arguably well paid and have had greater increases than I can say now even the Members of Congress.

But the real issue is that there is nothing in your statement, and I suspect that that is a purposeful omission, that talks specifically with limiting the aggregate dollars, and we have two other groups who have suggested to us ways that this can be done. And I rather suspect that whether it is this year or next year the Congress is going to do that.

What is troublesome to me is that most all of the other groups are willing to participate, and as you heard the testimony here today, to join with us in finding a way to cap the volume and the aggregate dollars.

My question is, in the absence of any specific study that the AMA is looking for, why won't the AMA join with us in saying that, one, we have some consensus on the fact there needs to be adjustment to the fee schedule, and I suspect there is some consensus building to have aggregate caps. The real question is going to be how we get those caps on the aggregate expenditures enforced.

And the reason that the AMA could be very useful it seems to me in something like that is that we are going to need a self-enforcement mechanism, and they might very well play a major role. If you maintain your present course, which is head in the sand and hope it will go away, there really isn't any need for us to negotiate with you. You don't add anything to it. You keep saying you want a study. And if this committee is going to go ahead and do one, I just suggest that to you and your board or whoever makes these decisions that if you want to play, you want to participate, "no" is not a negotiating stance. "No" is no negotiation. I don't know how you plan to have any input to this.

Dr. **Painter**. Let me respond by simply saying that AMA is already undertaking a study with the—joint studies with The RAND Corporation focusing in on practice parameters.

Chairman **Stark**. Who is going to pay for those studies?

Dr. **Painter**. That is being funded by AMA as I understand it, and we will then have indicated that we will complete that study by the end of—5 of the parameters by the end of this year and 10 by the end of next year.

Chairman **Stark**. What is that study intended to study?

Dr. **Painter**. It is intended to look at those areas of medicine in which there is no common agreement on what is the most appropriate and develop a consensus that will then give us the parameters relating to a specific disease or a treatment in which a physician——

Chairman STARK. How does that deal with the aggregate expense?

Dr. PAINTER. If you will allow me—the way it will deal with aggregate expense is that as that is developed then we can take it to our physicians and get them to incorporate better, more efficient care in their practice.

Chairman STARK. OK. That is fine.

Dr. PAINTER. And that will begin to deal with the volume.

Chairman STARK. Let's say I will give you that. However it comes out, I will stipulate that is what we will have. But let's say then the aggregate expense is too big. What do we do then?

We take the RAND study and we will incorporate it. This is the way you ought to treat the flu, or this is the way you ought to treat appendicitis. Three of these procedures and two of these and one of these, and this is the fee we have agreed to. And, lo and behold, medical expenses go up 20 percent. Then what do we do?

Dr. PAINTER. Well, I think what we have to do is look at how you want to distribute the dollars.

Chairman STARK. Charge the taxpayers to increase your income or charge the beneficiaries. I mean, sooner or later you are going to have to deal with the fact that the docs have to give something to this. They can't get ever more. They don't have a blank check. Everybody has got to be willing to give a little financially, and we are not hearing that.

We are hearing it from others. Every other subspecialty has either come to our committee in previous years or was here this year willing to take some of the heat. The AMA is saying—don't address that. They are saying ration the care to the beneficiaries, charge more to the taxpayers. How about the docs taking a little less income?

Dr. PAINTER. Well, I think what we should point out is——

Chairman STARK. Would you pay for that or not?

Dr. PAINTER [continuing]. That the fees that we have had——

Chairman STARK. No, income——

Dr. PAINTER [continuing]. Are really behind the inflation. One, the increased assignment rate which we have taken I think is important. We went through a fee freeze of some 40 months, as you realize.

Chairman STARK. But the fee freeze had nothing to do with your incomes, which went up between 12 and 15 percent a year compounded. So the fee freeze had no effect on the net income of doctors, as reported by the AMA.

Dr. PAINTER. The MEI, of course, is put in to limit the amount that you can increase your fees, and then we have the maximum allowable actual charge. I think those factors are important.

I think there is one other area that you might consider in your thinking, and that is that 80 percent of our Medicare beneficiaries now have medigap insurance. That has effectively removed the copay and deductible part of what they pay as well as supply other benefits.

In effect, the original model which was designed to reduce—provide financial incentives to the patient that they had to participate in, has been removed and we now see an increased demand. Our patients are coming in and saying we have heard about this. We think it will help. We now know we can get cataract surgery, be out in an hour, be home in 2 hours, and have our sight restored. So the demand side is another thing which I think needs to be addressed as part of the situation.

Chairman STARK. Wouldn't you think that maybe there is a possibility that the ophthalmologist might take a little bit less for each procedure? That has been going up at a rate of 15 or 20 percent, while the time necessary to do it has been coming down and the learning curve has been getting flatter as they can learn or are trained in 2 hours instead of 2 months, and yet their fees go up.

All I have heard today is the poor beneficiary better pay more. That will slow it down. The taxpayer better pay more. That will help. I have never heard one word that the doctors might take a little less. And until you are ready to negotiate with us on that, your testimony becomes very irrelevant. It is let the other guy pay, and that hardly seems like you want to play with us in good faith.

Dr. PAINTER. Well, let me respond by saying the ophthalmologist as well as other specialties in joining in the RBRVS is participating in, if it is adopted, a more equitable type of arrangement that takes into account the work and the practice cost and generates the actual fee. So we think that there needs to be a complete revision of the current system to get rid of a number of the inequities, and then the RBRVS will provide the framework for——

Chairman STARK. Do you think there is any limit on what percentage of our gross national product ought to be spent in physicians' fees? Is there any limit that you can imagine?

Dr. PAINTER. I think that in general the key question is medical care a product; and, if it is a product that people are purchasing like going on vacation or going buying clothes or buying any other essential ingredient, do the people want to put a limit on their access to medical care? Do they want a cap? Would they rather spend their money on good health care or some other aspect of the economy?

After all, medicine and health care is, of course, an industry in the sense that it hires a lot of people and does contribute to the economy as well.

Chairman STARK. I don't think you answered my question. I just said is there any limit? Should there be any limit at any time on what this country pays to doctors as a group?

Dr. PAINTER. I think that is an answer that the people of this country are going to need to provide. Do they want to have a definite cap? And if so——

Chairman STARK. Let's assume for a minute that is the decision of the people who elect us and speak through us as their representative, and let's assume for a minute that a majority of us are going to say yes, we want a cap, aggregate cap this year.

Now what is the best way and how are you going to work with us to achieve that?

Dr. PAINTER. A cap on——

Chairman STARK. Aggregate expenditure.

Dr. PAINTER. For health care generally?

Chairman STARK. For part B. That is what we are concerned with right now, the doctors' fees.

Dr. **Painter**. I think the key on that would be if there were to be that cap we would have to look at what the cap was and look at what the priorities are within that framework and try to come up with where it ought to go.

Chairman **Stark**. OK. As the President likes to say, read my lips, Doctor. There is going to be a cap. And whether we do it here, you don't get it from this committee, you are going to get it from the major unions and the major manufacturers and the major insurers in this country. It is not something unique to this subcommittee. If you can read the public press without moving your lips, you know as well as I do that there is mounting concern for the increased cost of the medical delivery system, and that includes physicians' fees.

There is going to be an aggregate cap. And the question is do you want to participate in designing that or do you want to see everybody else design it and see the AMA left out? And all I am suggesting is that the business of getting things done here is the business of negotiation and compromise, and that basically relative to the cap the AMA is not compromising, nor are they suggesting anything except alternative horror stories, rationing.

And the cap is very likely to cut into the aggregate amount of dollars that physicians receive. I understand that. And you can say under no circumstances will you support that, which is understandable. I mean, many associations take that position with us. And then we say fine. Then there is no reason to have you at the bargaining table, and you can lobby, as you have in the past, to beat issues. Where we have cut deals with subspecialties, the AMA has lobbied against it and often won. But the pendulum swings, and when the time comes to put the cap on, the AMA is not going to be at the table unless they have something to negotiate with.

And I would just commend you to go back—it is an understandable position. If that is the AMA's position, fine. Be proud of it. Don't waffle around it. You can't have both ends of that teeter-totter in the air at the same time. You have said cut back on services to beneficiaries. I don't think we are going to do that entirely. You have said have the taxpayers pay more. Do that. Fine.

The question is, if you want to say don't touch the aggregate amount you pay to physicians, leave that. If you don't have a cap, the other side of that coin is leave it open-ended. And if there is no moving off that position, it would be more helpful, save you a lot of effort and time just to say that is the AMA's position and you are not going to participate in any discussion where there is a cap. Then we will go on without you.

I am reading into your testimony that position. And if that isn't the case, I hope you will enlighten us soon. Because the specialists, the surgeons came in, said we want a deal and we understand there has got to be a cap. And these are surgeons that I know and I know that we had with us today one of the most highly respected surgeons in the entire United States. And he does not come here saying that lightly because, even though he and I were classmates in college, I am sure our philosophies have diverged over the years.

But the radiologists came to see us, the emergency room physicians came to see us, and indeed your own specialty, the internists, are willing to deal. It is just a matter of great wonder to me that the AMA and the NRA are about the only two trade organizations in this country that think they can stonewall progress. And I hope that we will see you back here again soon where the AMA can contribute something other than being naysayers.

Dr. PAINTER. Well, Mr. Chairman, your message is quite clear, and certainly I will take it back to the AMA and deliver what you have said and bring it to their attention.

Chairman STARK. Thank you very much.

Dr. PAINTER. Thank you.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

[Submissions for the record follow:]

American
Dental
Association

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Statement of
The American Dental Association
on
Physician Payment Reforms in Medicare

Submitted to
The Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives
March 21, 1989

The American Dental Association appreciates this opportunity to express its views on proposed reforms to the system of physician payment in Medicare and particularly the Resource-Based Relative Value Scale developed by William C. Hsiao, Ph.D., Harvard University.

The Medicare program, as now constructed, includes relatively few dental procedures and those that are included are of a surgical nature. The American Association of Oral and Maxillofacial Surgeons, representing the dental speciality most directly involved in Medicare, has presented its analysis and criticisms of the Harvard system to the Physician Payment Review Commission. The American Dental Association has advised the Commission that it is in substantive agreement with that presentation.

But, despite the general exclusion of dental procedures in Medicare at this time, the Association believes that the system of physician payment that the Congress eventually enacts for Medicare will strongly influence other health benefits programs, public and private. While certainly there are many similarities in the responsibilities of physicians and dentists to patients, in the delivery of medical and dental services and in the benefit programs that assist in payment for those services, there are crucial differences as well. For this reason, we consider it advisable to present to the Subcommittee those factors related to the delivery of and payment for dental care that render the application to dentistry of the Harvard system (or any resource-based relative value system) unnecessary and, indeed, inappropriate.

Most fundamentally, the forces that influence and to a considerable degree shape the dental care market have traditionally been efficient and remain so. Why this has been the dental experience and not the medical (in many disciplines, at least) is attributable, we believe, to these circumstances:

- Dental benefits have achieved less acceptance in the population than hospital-medical-surgical benefits (approximately 100 million persons currently covered for dental as opposed to about 190 million).
- Virtually all dental benefit programs contain substantial cost-sharing provisions, especially for the more extensive, and expensive, procedures. This has been true since the inception of dental benefit programs 35 years ago.
- The mix of covered and uncovered individuals who pay part or all of the cost for dental treatment results in approximately two of every three dollars spent on dental care being paid out-of-pocket, a proportion not expected to change through the year 2020.
- ADA-member dentists (about 3 of 4 dentists) are ethically prohibited from charging higher fees to their patients with benefits than they charge to their other patients.

- By their nature, most dental conditions are neither life-threatening nor of such severity that the patient's usual consumer purchasing considerations are negated or greatly diminished when seeking the most appropriate treatment. Even in the instance of dental emergencies, where acute pain is present, the immediate palliative treatment sought ordinarily involves relatively inexpensive procedures.

- The majority of dental conditions are susceptible to alternative treatment procedures, (not necessarily equally effective, but at least adequate), with substantial differences in their costs.

With respect to a resource-based relative value scale's serving to correct fee inequities created by uneven coverages and gaps in coverage across procedures, such inequities, by and large, do not exist in the dental market. Most practicing dentists (4 out of 5) are general practitioners who, for the most part, provide a full range of dental procedures.

The result in dentistry is a market in which consumer-patients seek treatment at their discretion (within a reasonable time-frame), make judgments about the cost of care and choose between alternative courses of treatment. The dental market is controlled by the effective demand for services. Thus, dental practices are extremely sensitive to local market conditions. We believe the measure of the accuracy of this description is the Consumer Price Index, in which, since 1968, the rise in the cost of all services has been 314.9%; of dentists' services, 297.4%; of medical care, 363.5%; of physicians' services, 366%; and of hospital services 678.8%.

We believe the efficiency of the dental market is due largely to the fact that the payment systems in dental benefit programs are based on actual charges. The most widely used system for reimbursing dental treatment is based on the dentist's "usual, reasonable and customary" fees, which is very similar to the CPR system used to reimburse physicians for medical services.

The difference between the two systems rests mainly with the providers they reimburse. The apparent inequity created for physicians by the CPR is due to the diversity of practices, i.e., cognitive versus procedural. With very few exceptions, dental services are procedural.

Admittedly, to be effective, URC systems require consistency in their structure and, in their operation, rigorous continuing attention to the market that forms their base. For the past two years, the Association has been cooperating with the National Association of Insurance Commissioners in the development of guidelines for the consistent and accurate administration of URC dental programs. This project has consumed considerable Association resources. We contend, however, that the complexities we have encountered in examining the URC approach are minor when compared with the administrative effort that would be required to maintain a resource-based relative value scale as an accurate reflection of dental practice over time.

Because the Subcommittee is addressing physician payment in Medicare, the concerns we have expressed may appear irrelevant. But at some future time, the scope of Medicare coverage may expand and, even if dental services are never included in the program, the potential influence of Medicare payment reforms on other benefit programs should not be ignored. Accordingly, we request that the Subcommittee acknowledge in its report the distinctions we have delineated, which, we believe, make the application to dentistry of the Harvard system or any resource-based relative value system inappropriate.

THE AMERICAN GERIATRICS SOCIETY
770 Lexington Avenue, Suite 400, New York, N.Y. 10021 (212) 308-1414

Linda Hiddemen Barondess
Executive Vice President

April 6, 1989

Robert J. Leonard
Chief Counsel
Committee on Ways and Means
US House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Mr. Leonard:

The American Geriatrics Society (AGS) is a professional organization whose membership includes over 5,000 physicians, in both practice and academic settings, who provide care for the elderly. The Society has a keen interest in your deliberations concerning the Physician Payment Review Commission's Report to Congress and reimbursement for physician services under Medicare. The Society has submitted testimony to the Physician Payment Review Commission in response to their 1989 Report to Congress. A copy of our testimony is attached to this letter.

The following is an outline of some of the key issues

1. Physicians who limit or focus their practices on the care of the elderly are almost totally dependent on Medicare and Medicaid reimbursement. There is little chance for "cross-subsidization" from patients who pay full charges. Further, because those with expertise in geriatric medicine tend to treat patients with severe chronic illness and who are of very advanced age, "balance billing" is uncommon among geriatricians. Thus, while the AGS supports measures to reduce the burden of balance billing on the frail elderly, we would also urge that payment for home and office visits be tied to a level that more accurately reflects the time and effort involved in providing the service.

2. We strongly support redressing the balance between technical procedures and cognitive services. Because of the diminished physiological reserves and relatively short life expectancies in many elderly persons with chronic illness, technology must be applied with increased caution. In addition, physical, cognitive, and communicative disorders, which are not uncommon in the frail elderly, require increased time and effort for the basic assessment of health problems. For these reasons, we could not support a resource-based relative

value scale based on historical charges.

3. Comprehensive Geriatric Assessment, a process that was the focus of a recent National Institutes of Health Consensus Conference, has been shown to be effective in improving outcomes and, in some cases, reducing overall health care expenditures. We would urge you to consider Comprehensive Geriatric Assessment as a procedure that could be reimbursed under Medicare. We would be glad to provide technical assistance in defining the procedure, with "bundling" of a number of services, and in setting reasonable limits to its utilization and pricing.

4. Data on the use of physician services by the frail elderly, and especially those over 84, indicate a relative under-use of physician services. While the use of hospital, home care, and nursing homes increases steeply with age and with multiple chronic illnesses, the use of out-patient physician services increases less than 15% from age 65 to age 85. Given the evidence from capitated health care systems that ambulatory care visits may reduce the use of hospital care, we would ask that you consider measures that might increase the relative use of home- and office-based visits by the frail elderly.

5. Because of the increased vulnerability of the frail elderly to abuse or exploitation, developing adequate measures of quality of care that can be applied by organizations, such as PROs, is of vital importance to the effective and efficient care of this group of patients. It is often difficult or impossible for the frail elderly to register complaints or to seek an alternative source of physician services.

6. There is a critical need for studies or diagnostic and therapeutic efficacy in the elderly, and especially in those over 75 or 80 years of age. The alteration in physiologic reserve, shortened life expectancy, and increased incidence and prevalence of disease are just a few of the characteristics of the older patient that may change the efficacy of diagnostic or therapeutic interventions. Many technologies are applied to the elderly population with little or no prior testing using a comparable age- and illness-matched group.

7. While capitation, especially in the form of the so-called Social Health Maintenance Organization, offer promise of improving the overall care of the elderly, the present

system of capitation strongly encourages the exclusion of the older, frail elderly from capitated systems. Indeed, one can make a strong argument that it is precisely the frail elderly person with multiple, high cost chronic illnesses, whose care is most likely to be made more efficient by the managed care provided by many HMOs. We are concerned that the current system, using the AAPCC, has encouraged HMOs to slant their marketing to the healthy elderly, resulting in actual increased total costs to the Medicare system.

The careful and thoughtful approach of the Physician Payment Review Commission has already brought much needed rationality to this very complex and potentially divisive issue. We, in general, support the positions taken in the Commission's 1989 Report to Congress and ask that you give consideration to the issues outlined above as you review the PPRC's Report.

Sincerely,

Richard H. Ham

Richard H. Ham, MD
President, American Geriatrics Society

L. Gregory Pawlson

L. Gregory Pawlson, MD
President-elect, American Geriatrics Society

Testimony of the American Geriatrics Society
to the
Physician Payment Review Commission

February 8, 1989

Richard W. Lindsay, MD
Chairman of the Board

American Geriatrics Society

The 5,000 physicians and health care professionals who are members of the American Geriatrics Society are dedicated to the advancement of research, education, and clinical practice related to the medical care of older persons. Most important for this Commission is that the clinical care provided by our members is focused almost exclusively on Medicare beneficiaries, and most often on those older persons with multiple illnesses and impairments of physical, cognitive, behavioral, and/or social functioning. In addition to the usual physician-patient relationship, and in concert with nurses, social workers, and other health care professionals, the geriatrician often plays an advocacy role--on behalf of this group of patients. Geriatrics is also assuming a more prominent role within medicine. There are now a growing number of accredited fellowship programs in geriatric medicine. The American Boards of Internal Medicine and Family Practice have created a joint certificate of added competency examination in geriatric medicine, the Board of Psychiatry and Neurology may follow in the near future.

There are still relatively few geriatricians and continuing controversy as to whether geriatrics is a unique clinical subspecialty. However, the fact that there is a group of physicians who provide services exclusively for Medicare beneficiaries and, specifically, the so-called frail elderly, raises several important issues for the Commission to consider in evaluating the equity of Medicare physician reimbursement.

1. Because Medicare and Medicaid reimbursement is often the sole source of clinical income for physicians specializing in the care of the frail elderly, they are unable to "cross-

subsidize" revenues from private pay patients.

2. Because the frail elderly, in general, have limited incomes, high medical care expenses, and may have difficulty in filing multiple Medicare claims, the American Geriatrics Society encourages its members to accept assignment on all, or nearly all, claims. However, present Medicare reimbursement policies create major dilemmas for physicians in some rural areas of the country and for physicians who provide mostly evaluation and management services.

3. The vast majority of services provided by geriatricians are evaluation and management, providing little opportunity for high revenue to time technical procedures.

4. The use of multiple professionals in an interdisciplinary team is a major tenet of geriatric practice.

5. Comprehensive geriatric assessment (CGA), which many geriatricians feel is a hallmark of geriatric practice and for which a substantial literature exists on its effectiveness, does not have a CPT-4 code nor is it recognized by the Health Care Financing Administration (HCFA) as a reimbursable procedure by Medicare.

More important for the beneficiaries of Medicare is the need for a reimbursement system that:

1. Encourages physicians to provide services for older persons with severe chronic illness and functional impairment.

2. Recognizes that the care of the frail elderly requires more detailed attention as to how and when the application of expensive and invasive technologies is truly beneficial.

3. Protects the beneficiary with high medical and self-care expenses from excessive out-of-pocket expenses.

4. Does not create needlessly complex claims forms and confusing information about self-pay costs for those who have frequent need for medical care services.

For these reasons, we continue to support the development of a fee schedule that is based on a resource-based relative value scale (RBRVS) for reimbursement of physicians in the Medicare program. We appreciate the attention that the Physician Payment Review Commission gave our testimony at the November 1988 session. We would like to offer a few added general observations concerning the RBRVS as well as to comment on issues, which the Commission will address in its March report to Congress, that are germane to our Society and, we hope, to the patients for whom we provide care.

1. Review and evaluation of the Hsiao study: While we continue to support the validity of the study, we feel that devising a fee schedule specifically for the Medicare program will require additional studies focused on services that are more

characteristic of persons served by the Medicare program.

The vignettes used by Hsiao et al, while valid for a general population, did not contain a representative number of examples of the care of older persons with multiple diseases and impairment in cognitive, physical, or behavioral-social function. We believe that these persons may require a greater amount of physician time before, during, and after most services (especially service in the evaluation and management category). In addition, the overhead costs for services provided to the frail elderly may be higher than those for less impaired older persons. For example, in the ambulatory care visit, more staff time may be required to ensure that the patient is able to get to the office and into the examination room and is safe there, to provide communication to family and patient, and to arrange for follow-up testing and/or other management.

We strongly recommend that the PPRC and Congress recognize the need for further study of the problems in the Hsiao study, relating to evaluation and management services provided to the frail elderly. We would ask that the PPRC, or Hsiao and his colleagues, develop and test a series of vignettes involving the care of frail elderly patients in outpatient, nursing home, and hospital settings to determine (and specify) the work involved in the care of these individuals.

2. Coding of visits: The current CPT-4 codes clearly do not adequately cover the heterogeneity of time, technical skill, or level of mental effort provided in office visits. In addition to the suggestions noted above, we would like the Commission to specifically address the emerging evaluation and management service known as comprehensive geriatric assessment (CGA). This service, which may be provided in hospital, nursing home, or outpatient settings, includes a medical history and physical exam, together with an evaluation of cognition, psycho-social, and physical functioning, and the development of a plan of management for the problems identified. A National Institutes of Health consensus conference, numerous articles in the medical literature, and several professional organizations have concluded that comprehensive geriatric assessment appears to be effective in the management of certain persons with multiple problems. Yet, there is no current CPT-4 code or reimbursement for this procedure. While there is an ad hoc committee of the AGS working on defining these procedures and the work involved in producing them, we do not have the resources at present to recommend a set of codes and relative value for this service.

We urge the PPRC to recommend to Congress that CGA be recognized with specific CPT-4 codes and as a procedure that is reimbursable by Medicare. The technical work necessary to refine the definition of CGA, develop the appropriate codes, and determine the criteria limiting the population and frequency of application of the procedure can easily be accomplished within six to eight months by the PPRC and HCFA with technical input from the AGS.

3. Specialty differentials, training costs, and practice costs: These areas present a major issue for geriatrics and subspecialties that rely primarily on evaluation and management services for reimbursement. Theoretically, the costs resulting from intensity of effort, extent of training, and practice overhead, can be included in the reimbursement for a given procedure, thus eliminating the need for specialty differentials. However, consider the following scenario: A geriatrician and her interdisciplinary team provides a follow-up visit to a frail, elderly patient. Assume that this evaluation and management service is provided in the same amount of time but with more intensive use of personnel and the geriatrician (as a comprehensive office visit by a general internist or family practitioner). Unless the visit to the geriatrician is coded separately, the additional cost of training and overhead will not be recognized. It is appropriate to recognize the added training and office overhead costs of the orthopedic surgeon in performing a total hip replacement, but neither the physician who requires additional training nor the office personnel who provide specialized management and evaluation services?

We recommend that the PPRC study evaluation and management services other than CGA that are provided by geriatricians to see if sufficient differences exist that would justify separate codes and reimbursement. This is separate from the study of CGA.

4. Assignment: With the present inequities in the Medicare reimbursement system and the higher reimbursement available from some private insurers, balance billing has remained a significant problem for both physicians and some Medicare beneficiaries. An appropriately constructed fee schedule should help reduce the pressure felt by some physicians to balance bills. However, in other areas of medical practice, balance billing could become more prevalent. While we cannot take a final position on balance billing and mandatory assignment until more is known about the final form of the Medicare fee schedule, we do believe that it is important to protect those elderly persons with high medical expenses and moderate or low incomes from the added burden imposed by balance billing. Requiring assignment on Medicare beneficiaries who exceed the deductible defined in the recent Medicare catastrophic care law would do this, limiting balance billing to a fixed percentage and absolute dollar limit (as actual charges not exceeding the Medicare schedule by 12% or $500, which ever was less) should be considered. To impose such limits and still maintain access for Medicare patients, however, requires that the amount paid in a Medicare fee schedule remain reasonably close to those of other insurers. To impose even limited mandatory assignment or strict limits on balance billing, in the face of Medicare reimbursement that was markedly lower than other insurers, would create second class citizenship for older persons and the health professionals that choose to serve them.

The Commission and Congress face a unique and very difficult challenge in reforming the Medicare reimbursement system to meet the goals enunciated in your initial report to Congress. We believe the Commission has made very significant progress toward those goals, and we look forward to working with you on those issues that must still be resolved.

Statement of the American Optometric Association

The American Optometric Association (AOA), on behalf of its 26,000 members and their patients is pleased to submit its comments regarding a number of physician payment issues now being considered by the Committee. The Association has been devoting considerable resources to the consideration of important Medicare physician payment policy matters, and we have been in regular communication with the Physician Payment Review Commission (PPRC) about these issues. Doctors of optometry are included in the definition of physician under the Medicare statute and would be affected by changes in Medicare's physician payment policy.

Specialty Distinctions

Doctors of optometry were not among the specialists studied during the first phase of the Harvard resource-based relative value scale (RBRVS) study nor are they among the specialties to be studied during phase II of the Harvard project. However, eye care services provided by ophthalmologists, some of which are also provided by optometrists, were examined by Dr. Hsiao and his Harvard colleagues.

Since a change in Medicare's physician payment system would affect the services provided by optometrists, we have been concerned about the way in which these services and those of other physician specialties not included in the Harvard study would be treated.

Although the RBRVS study has resulted in specialty-specific resource-based relative values for a service performed by more than one specialty, the AOA strongly believes that such specialty-based differentials are generally not justified. In particular, given the fact that many experts speak of the need to enhance the competitive nature of the health care marketplace, we would find it odd if Medicare were to choose to make specialty-based differential payments for the same service.

On several previous occasions, the Association communicated to the PPRC our support for the concept of equal payment for the same service, and we are pleased that the Commission is recommending that specialty payment differentials be kept to a minimum under the new fee schedule it has proposed.

We share the PPRC's view that specialty differentials are not justified in the absence of evidence demonstrating a difference in a particular service by specialty. In this regard, it is important to note that doctors of optometry are primary care providers who are specialists in the rendering of eye/vision services. As such, they receive substantially more training in that specialty than physicians in general and, for the services they provide, their training is similar to the specialty training of allopaths and osteopaths for the provision of the services provided by all three practitioner groups. Put another way, the higher level of training received by allopaths and osteopaths specializing in eye/vision services is related to surgical care and treatment of special medical disorders, not the diagnostic and treatment services that are provided by all three practitioner groups.

In addition to passing a three part national board examination as a condition of licensure, most optometrists, like many other practitioners, are required to participate in a substantial continuing education program.

Comanagement of Post-Operative Care

Another issue of considerable interest to the Association's members is the manner in which Medicare payment will be made in instances where the surgical care of a patient is managed by more than one provider. Such comanagement of the cataract patient is increasingly commonplace. Under current practice, Medicare carriers are, to a large extent, free to define the package of services considered included in the surgical global fee, and to determine payment levels in instances where some or all of the post-operative care is provided by the non-operating provider (either a doctor of optometry or ophthalmologist). This situation results in an inconsistent, and oftentimes inequitable, application of global periods and payment levels.

The AOA is pleased that the PPRC has devoted considerable resources to issues relating to the definition and coding of physician services. The Commission's Panel to Standardize Codes for Surgical Global Fees has recommended that when a physician other than the principal surgeon provides a service that is included in the global package, the principal surgeon's fee should be reduced based on the resource costs of the post-operative hospital and/or office visits that are used to calculate the global fee. The PPRC has endorsed this recommendation.

Building upon this PPRC-endorsed premise, the AOA recommends the following specific approaches for dealing with the comanagement of surgical patients, including those undergoing cataract and other eye surgery:

- A global fee should be paid to the comanaging physician, (either doctor of optometry or ophthalmologist) based upon the resource costs associated with providing such care in the average case.
- For cataract patients, such a global fee would be paid when the comanaging physician provides services to a patient at least two or more times during the post-operative period, and would be based on the resources associated with the four to six post-operative visits provided, on average, in such cases.
- Based on experience in treating the post-operative cataract patient, we believe that the global period for an uncomplicated cataract surgery should be six to eight weeks.
- Consistent with the earlier comments about specialty distinctions, the global payment for post-operative care should be the same whether provided by the comanaging physician (e.g. a doctor of optometry or an ophthalmologist) or by the principal surgeon.

The AOA believes that the resulting standardized definitions of care, including post-operative care provided in a comanagement situation, and a standardized approach for valuing and paying for such services -- under a global fee arrangement -- would be a significant improvement over the current rather chaotic manner in which payment policy for these services is determined.

Primary Care Services

In 1987, Congress approved a more favorable treatment of certain primary care services. Under provisions of the Omnibus Budget Reconciliation Act of 1987, the prevailing charges for these primary care services are subject to higher rates of increase. The law defined primary care services as: office medical services, emergency department services, home medical services, and nursing home services, and the accompanying conference report listed the CPT-4 codes that were considered included.

Although the PPRC and the Congress are devoting considerable energies toward long-term reform of Medicare's physician payment system, AOA anticipates that the current policy distinction between primary care and non-primary care services will continue to apply for at least one more year.

Unfortunately, the peculiarities of the CPT-4 coding system used by Medicare to report physicians' services appear to have caused the Congress to overlook certain primary care services in setting out the 1987 policy change. Specifically, brief or limited eye/vision care visits, for new and established patients, are reported using CPT-4 codes 90000, 90010, 90030 and 90050, the same codes used in reporting office visits unrelated to eye care. However, intermediate and comprehensive office visits for eye/vision care must be reported using special codes devoted to general ophthalmological services (i.e. 92002, 92004, 92012 and 92014). Thus, as a result, under the 1987 law, brief and limited vision care visits are considered primary care -- and subject to the more favorable payment policy -- while intermediate and comprehensive vision care visits are not.

AOA strongly believes that the omission of intermediate and comprehensive vision care visits from the list of primary care services is not in keeping with Congress' desire to provide more favorable treatment for primary care services. Thus, we urge the Committee to consider revising current policy so that all primary care services -- including all primary vision care services -- will be treated in a consistent manner.

Conclusion

AOA appreciates this opportunity to present our views regarding a number of physician payment issues. The Association looks forward to working with the Committee as it considers these and related matters.

STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

ON

RECOMMENDATIONS OF THE PHYSICIAN PAYMENT REVIEW COMMISSION

MARCH, 1989

The American Society of Internal Medicine (ASIM) appreciates the opportunity to present its preliminary evaluation of several of the recommendations made by the Physician Payment Review Commission (PPRC) on reform of the existing system of reimbursement under Medicare. Given the fact the we have not yet had the opportunity to review the Commission's annual report to Congress, this statement should be reviewed as a preliminary evaluation based upon initial reports on the Commission's likely recommendations, rather than a conclusive statement of policy. We expect to provide Congress with an expanded and more complete statement once we have had an opportunity to review the Commission's written recommendations.

Implementation of a Fee Schedule Based on the RBRVS

The Commission is expected to recommend that Congress mandate implementation of a fee schedule based on the Harvard Resource Based Relative Value Scale (RBRVS) beginning on April 1, 1990, and phased in over a two year period with the new payment rates taking full effect on April 1, 1992.

ASIM strongly supports this recommendation. The Harvard RBRVS, as refined by the Commission, is the product of more than ten years of debate, research, and analysis. It reflects the desire of Congress, as reflected in the Omnibus Budget Reconciliation Acts of 1985, 1986 and 1987, to correct distortions in the existing pricing system that favor high cost technological services over evaluation and management (otherwise known as cognitive) services. Timely implementation of a fee schedule based on the RBRVS offers significant advantages for payors and beneficiaries, including:

- It will correct existing incentives that may adversely affect the volume of services provided to Medicare beneficiaries. By no longer paying physicians disproportionately higher for the work involved in invasive procedures compared to evaluation and management services, physicians no longer will have an incentive to substitute expensive technological procedures for cost-effective evaluation and management services. As such, the RBRVS is an important step toward ensuring that medical decisions are based solely on what is best for the patient, not on which service or procedure is the most financially rewarding. Although a fee schedule based on the RBRVS will not by itself completely solve the "volume" problem, it is an essential part of a comprehensive strategy to assuring that only effective and appropriate services are provided to Medicare patients.

- Physicians will no longer be penalized for spending time with patients. Public opinion surveys show that patients' number one complaint about physicians is that they do not spend an adequate amount of time with them. The RBRVS, by paying more appropriately for the time spent in providing evaluate and management services, will make it possible for physicians to spend significantly more time with their patients.

- It will simplify the Medicare program. Beneficiaries will be able to anticipate in advance how much Medicare will pay for a given service, and thereby better understand their potential out-of-pocket liability. An RBRVS fee schedule will also facilitate competitive pricing for physician services.

- It will improve access to primary care services, particularly in rural areas. By paying better for evaluation and management services, and by correcting geographic inequities, physicians will have an incentive to enter primary care specialties and to practice in underserved areas.

On other issues relating to the Commission's recommendations on an RBRVS fee schedule, ASIM:

- Supports incorporating average time descriptors in CPT-4 codes for visit services.

- Supports establishing the initial dollar conversion factor at a budget neutral level.

- Supports limiting variations in payment levels by region only to actual differences in the cost of providing services (overhead). This will significantly improve access to physician services in underserved rural and inner city communities.

- Supports the concept of establishing an appropriate "safety net" to protect low-income beneficiaries from excessively high out-of-pocket expenses. ASIM strongly believes, however, that it is inappropriate and unnecessary to establish an overall limit on charges to all beneficiaries at some percentile level above the payment levels established by the fee schedule. Such a requirement, in ASIM's view, is a prescription for mediocrity. In every field, whether talking about an engineer, attorney, architect, or accountant, there are some individuals that have more experience, greater expertise, and offer a better service than the norm for their field. Those individuals typically and appropriately charge more for their services than the average. This is as true in medicine as it is in any other field of endeavor. Patients should have the right to select physicians who bring greater skill to treating their individual problems, and who therefore have an appropriately higher charge. Limiting all physician fees to some pre-determined percentile above the RBRVS fee schedule would preclude that choice. It would also act as an discentive for physicians to obtain additional skills and training, since there would be no additional compensation to recoup the cost of such training. Any fee schedule, even one based on resource costs, by its nature represents a standard or average; balance billing is the only way to recognize differences in the skill and training of individual physicians, and in the needs and desires of individual patients.

Consequently, ASIM strongly urges Congress to move expeditiously on mandating implementation of a fee schedule based on the RBRVS, as recommended by the Physician Payment Review Commission, beginning on April, 1990. The new schedule would be fully in place by April 1, 1992. We also support appropriate measures to protect low-income beneficiaries from high out-of-pocket expenses, but urge Congress to reject the Commission's recommendation to establish an overall limit on charges to all beneficiaries.

Expenditure Targets

ASIM is surprised and disappointed that the Commission reportedly will recommend the establishment of a national expenditure target, taking into account estimated increases in price, volume, and number of beneficiaries, beginning on January 1, 1990. Although details of this proposal have not yet been provided, spending on physician services that exceeds the expenditure target would lower future increases in payment levels (i.e., the conversion factor under the RBRVS fee schedule) in order to offset those higher spending levels. It is unclear at what level the expenditure target will be set, although presumably it will be established at a level that is below the estimated increase under current law in overall expenditures (price times volume of services).

We believe that this recommendation should not be accepted by Congress for at least the following reasons:

- Unlike the recommendation on the RBRVS fee schedule, which reflects over ten years of debate and evaluation, and three years of intensive work on the part of the Commission, the expenditure target concept has not undergone critical scrutiny. This concept has not been the primary focus of the Commission's hearings and work over the past several years. Consequently, the Commission has not had the benefit of the same type and degree of expert advice, public comment, and research that were reflected in its recommendation on the RBRVS fee schedule. This is unfortunate, particularly given the fact that the expenditure target approach could have even greater ramifications for the quality and accessibility of medical care in this country than a fee schedule.

- The purpose of the expenditure target approach is to limit services provided to Medicare beneficiaries. As such, it is a form of rationing. According to the dictionary, "ration" means to restrict to limited amounts. The Commission acknowledged in its March 1988 report to Congress that "the intent of expenditure targets is to make explicit to physicians the limits of the resources society has decided to make available for health care..." Presumably, the Commission intends for only "unnecessary" or "ineffective" services to be eliminated. Given the lack of data and consensus on the effectiveness of different medical services and procedures--and the inherent contradiction in attempting to set a limit on overall expenditures without any public consensus of how much *should* be spent on medical care--it takes a large and unjustified leap of faith to presume that only "waste" will be cut from the system.

Put into individual terms, expenditure targets can only work if individual doctors decline to provide certain services to their patients that they otherwise would have provided. *Without a scientific basis for making such a determination, however, it is just as likely that "effective" as "ineffective" services will be denied, particularly in grey areas where there is no clear consensus on what is the best way of treating a particular problem.* Consequently, it is the patient, not the physician, that is at risk under the expenditure target concept. This distorts the physician's traditional role as advocate of his or her patient, by placing the physician in the position of limiting services to patients in order to meet predetermined targets established by the federal government.

- It is unclear how the medical profession can collectively control utilization across the country in order to meet the expenditure target. An individual physician who practices a conservative style of medicine would still be financially penalized if overall expenditures exceed the expenditure target limit. Similarly, lower cost regions of the country will be at risk for higher utilization in other parts of the nation. Physicians in one specialty will similarly be at risk if physicians in other specialties increase their volume of services. Consequently, expenditure targets place individual physicians at risk for behavior by their colleagues that is outside their own control. Moreover, there is no organized system of utilization review now in place nationwide that would enable the profession to collective control the volume of services.

What is needed instead is the development of the data and scientific basis needed to establish guidelines for evaluating the effectiveness of different medical and surgical interventions. ASIM recently released a 14-point plan for controlling the volume of ineffective services. Copies are available from ASIM. A strategy designed to obtain the knowledge--and the means--for reviewing and evaluating the effectiveness of different ways of treating patients offers far more potential than expenditure targets for appropriately controlling the volume of ineffective medical services, without compromising patient care. By developing guidelines first for high volume procedures where it may be relatively easier to obtain a concensus on effectiveness, it is likely that the Medicare program can begin saving significant amounts of money in the relatively near future -- without resorting to the imposition of expenditure targets.

For these reasons, ASIM urges Congress to act cautiously before rushing into a decision on national expenditure targets. A cautious approach to making a decision on expenditure targets, however, should not preclude an early decision on implementation of an RBRVS fee schedule. Reform of the pricing system needs to be done regardless of what approach to the volume problem is ultimately decided upon by Congress. Moreover, unlike the expenditure target concept, the RBRVS fee schedule has a far longer track record of public debate, research, and evaluation that will enable Congress to make an informed decision now on the desirability of this policy recommendation. Therefore, it makes no sense to hold the decision on the RBRVS fee schedule hostage to making a final judgment on expenditure targets and alternative approaches to controlling volume.

STATEMENT

of the

AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS
to the

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

by

James G. Hoehn, MD

March 21, 1989

The American Society of Plastic and Reconstructive Surgeons (ASPRS) is the largest organization of plastic surgeons in the world. Requirements for active membership include certification by the American Board of Plastic Surgery. The ASPRS represents 98 percent of the 3,257 board certified plastic surgeons practicing in the United States and Canada. It serves as the primary educational resource for all plastic surgeons and as their voice on socioeconomic and legislative issues. The ASPRS is recognized as the spokesman for the specialty of plastic surgery by the American Medical Association (AMA), the American College of Surgeons (ACS) and other recognized organizations of specialty societies. This written statement is being submitted for consideration by the Committee and for inclusion in the printed record of the hearing.

The ASPRS has been actively involved in a thorough study of the payment policy issues which are relevent to physician reimbursement for medical and surgical services under Medicare. Initially, it is our opinion that the elements of the plan which has been presented by the American College of Surgeons (ACS) are comprehensive in addressing the current national concerns with physician reimbursement. The elements of the ACS plan are primarily focused on the quality of services, volume control, and cost of surgical services as they apply to Medicare patients.

As does the ACS, ASPRS believes the volume of physicians' services is related to the physician's judgement of medical necessity. We realize that such differences in "judgement" will necessitate the establishment and codification of physician-developed standards or guidelines in order to facilitate the process of volume control. This critical subject is not addressed in other proposals for reducing healthcare spending.

We also agree with the ACS' proposal in that "relying exclusively on physicians' judgments about the input costs of services in order to set relative values is conceptually incomplete." It is necessary to consider those elements of a physicians' practice that are generated from the supply-side, or resource-based, and those generated from the demand-side, including the patient interest and demand. Therefore, we support the ACS proposal of a "blended" approach towards supply- and demand-sided factors.

In addition, the ASPRS supports the ACS' proposal for a "national income level below which the new Medicare schedule of fees for surgical services would be considered as payment in full" (voluntary assignment). Such a change would serve as a way to protect both the physician and the patient. Physicians would still have the choice of accepting assignment in any other cases and older citizens would be provided with high quality medical care and economic protection.

At this time, the ASPRS also wishes to comment on the several items addressed in the Physician Payment Review Commission (PPRC) statement.

With regard to the relative value scale (RVS), the ASPRS supports the PPRC in its recommendation that the RVS be comprised of two cost elements: relative physician work and practice costs. The ASPRS supports adoption of a policy already developed by the PPRC to standardize the definition for all surgical "global" services. Concerning codes for surgical global services, the ASPRS supports the policy developed by the PPRC defining which services associated with an operation are to be included in the global payment for surgery and which are to be paid separately. The PPRC, using data from the Hsiao study, is calculating the relative values for each surgical procedure to conform to this policy.

The conversion factor transforms the RVS into a schedule of dollar payments for each service. The ASPRS feels strongly that the conversion factor should be modified by a 1) practice (geographic) cost factor, 2) malpracitce cost factor, and 3) a personal physician "care-delivery" factor (identifier). Like PPRC, the ASPRS recommends that the initial conversion factor be set so that outlays for physicians' services projected under the fee schedule are the same as those projected under the current payment system, i.e., budget neutral.

For practice costs, the ASPRS favors 1) use of the PPRC-developed additive formula for incorporating practice costs into the RVS, 2) initial use of the PPRC's refined estimates of practice costs by specialty, to be superceded by estimates of practice costs by category of service, and 3) developing a separate practice cost factor for professional liability insurance premiums.

Like the PPRC, the ASPRS recognizes that insurance coverage for professional liability represents a major cost to physicians that varies substantially by specialty and and geographic area. To assure that the fee schedule adequately accounts for differences among risk classes (e.g., physicians doing no surgery versus high risk surgical specialties) and localities (e.g., Florida Idaho) used in setting premium rates, the ASPRS recommends that professional liability insurance premiums should be treated as a separate practice cost factor.

Regarding geographic multipliers, the ASPRS supports PPRC's recommendation that the geographic multiplier reflect only variation in overhead costs of practice. The amount physicians received for their professional time and efforts, after subtracting overhead costs, should not vary by locality and therefore, should appropriately modify the RVS. Therefore, if physicians in two parts of the country provide the same quantity and mix of services to Medicare beneficiaries, they would receive the same net income from Medicare. The policy would reduce substantially the magnitude of geographic variation in fees.

In contrast to the PPRC, the ASPRS recommends that specialty differentials be included in the Medicare payment system. A physician certified by a board approved by the American Board of Medical Specialties (ABMS) has passed a rigorous examination given by a jury of his/her surgical peers. To alleviate this impass, the ASPRS recommends that a physician identifier system such as that used successfully in the past by the U.S. military be included in a restructured Medicare payment system to preserve incentives for quality training for physicians treating America's elderly citizens.

The ASPRS shares the PPRC's position regarding assignment and the AMA's opinion regarding balance billing. The ASPRS does not recommend mandatory assignment, but favors voluntary limitations of charges for unassigned claims. In addition, the ASPRS favors eliminating balance billing for qualified Medicare beneficiaries (age, income level as determinied by adjusted gross income).

In conclusion, the ASPRS has agreed to be a part of the Conjoint Council on Surgical Services to support the proposal of the American College of Surgeons and to assist in further developments which will be made in the near future. We recommend this highly comprehensive plan of action for addressing the current concerns with physician reimbursement under Medicare.

Statement of

The Health Industry Manufacturers Association

The Health Industry Manufacturers Association, known as HIMA, is pleased to have the opportunity to present our written statement on physician payment reform.

HIMA is a national trade association representing more than 325 manufacturers of medical devices, diagnostic products, and health care information systems. These are technologies used by physicians -- and increasingly by physicians in their offices.

Our statement speaks to one issue -- the resource-based relative value scale (RVS) -- and makes one point: As the Subcommittee works to make an RVS fair and effective for physicians, it should work also to make an RVS fair and effective for the tools physicians need to help patients.

The Physician Payment Review Commission's work on RVS, and that of Professor Hsiao, are thoughtful attempts to build a better system for physician payment. But this system will not be better unless at least two things are true:

- The original construction is sound.
- The system keeps working over time.

Our statement speaks to both these points. We are pleased that the Physician Payment Review Commission has taken significant steps to address these points. We urge the Subcommittee to do so as well.

I. RVS Construction Issues: Making Practice Cost Data More Accurate

Fundamentally, construction of a resource-based RVS should reflect just that: The resources physicians need to do their jobs. The Hsiao RVS attempts to do this in several ways. For now, we focus on his methodology for determining physician practice costs.

Identifying a physician's practice costs for technology is sometimes elusive:

- Use of medical technology varies by physician service and procedure.
- Use of medical technology varies (and increasingly so) by site of care.

Failure to address these complexities could result in incorrect judgments as to how much should be paid and confusion as to what is being paid for. It could also inappropriately skew decisions of physicians about what technologies to acquire and decisions of innovators about what research areas to pursue.

We are pleased that the Physician Payment Review Commission is exploring a methodology that would more precisely account for technology used by physicians. We support this and have been pleased to work with the Commission to facilitate a pilot survey to measure more accurately the technology component of practice costs.

We add our own thoughts below:

A. Use more current data

Professor Hsiao used the HCFA Physician Practice Cost and Income Survey. This survey collected cost data that was already five years old when the Hsiao report was released in 1988. And while Professor Hsiao, for that five-year period, assumed a relatively constant level of technology, it is far from clear that this basic assumption is correct. Moreover, his assumption that technology was uniform within and across specialties is to us suspect.

Three broad measures point up how much can happen in five years:

- Between fiscal year 1985 and 1988, the Food and Drug Administration approved more than 200 premarket approval applications (PMAs) for new medical devices. PMAs are required for devices that represent significant technological change.
- Between January 1983 and May 1988, HCFA issued more than 70 national Medicare coverage decisions. Most if not all of these decisions caused a change in the package of products and procedures that Medicare considers good medicine.
- In April 1987, HCFA significantly expanded the number of Medicare-covered ambulatory surgical center procedures, as evidenced by a four-fold increase -- from 400 to 1,600 -- in the number of codes for these procedures.

To be sure, none of these trends can be tied with precision to physician practice costs. They nonetheless underscore what intuitively we know to be true: Medicine has changed significantly in the last five years.

In addition to these trends, we note below more specific ways technologies have affected physician practice costs since the 1983 HCFA survey was conducted:

. New Technologies Have Been Introduced. Some technologies simply weren't being used (or used widely) at the time of the 1983 survey. In this category is use of lasers for cataract removal, a procedure now commonly employed to improve vision.

. Existing Technologies Have Been Used For New Indications. Other technologies, though in existence in 1983, were used in the years that followed to address new kinds of medical problems. Arthroscopic devices, for example, were used for knee surgery in 1983. But since then, incremental improvements in the device have allowed arthroscopy to be performed on wrists and temporomandibular joints.

. Existing Technologies Have Been Used At New Sites. Doppler ultrasound permits non-invasive monitoring of cardiac output. Since 1983, many of these procedures have moved to physicians' offices from other sites of care.

. Use of Supply Items Has Changed, Too. The examples above are at the upper reaches of technology. But changes have occurred in lower technology items, too. For example, AIDs has significantly increased the use of gloves, which physicians and their employees now wear during a wide range of medical and surgical interventions.

And finally, examples like those above make it hard for us to concur in Professor Hsiao's assumption that technology costs among specialties have stayed the same in a relative sense. For this to be true, technological change would have had to occur uniformly across specialties, across procedures within specialties, and across geographic areas. We believe innovation is too dynamic and pluralistic to conform to such neat symmetry.

In sum, the data accounts neither for technological change itself nor for its variation across medical specialties, procedures, and geographic areas. Without more current data, an RVS cannot adequately capture the physician practice costs the system is supposed to measure.

We recommend no RVS be implemented until it can be constructed with better current data.

B. Use a more precise methodology

1. A More Precise Survey

The HCFA data used by Hsiao is not only out of date; it is imprecise in what it measures:

- The survey did not request costs of specific medical technologies, only of overall equipment and supplies purchased.
- The survey may not have captured depreciation costs of equipment purchased in a year other than the year the survey was conducted.
- Price and volume may be inversely related. As the volume of products being purchased by a physician increases, the unit price may well decline. The same principle applies to the volume of procedures a physician provides. The more procedures across which the physician's costs can be spread, the lower the cost per procedure. It is not clear to us that Hsiao's survey reflects these subtleties.

But if it is unclear what is being measured, one point stands unambiguous: The survey used by Professor Hsiao does not adequately reflect the costs of a physician's technological resources.

2. A More Precise Allocation System

HIMA believes a physician's technological resources should in some fashion be tied to the individual procedures in which those resources are used. While we need to study further the Commission's methodology for incorporating practice costs into the RVS, it appears to allocate practice costs more precise than Professor Hsiao's approach. We comment on Professor Hsiao's approach below.

As the Commission has pointed out, the Hsiao methodology is built around average practice costs for each medical specialty. Thus, Professor Hsiao allocates the practice costs for use of technology for a given procedure at the same rate for all procedures in that specialty, even though procedures within a specialty (and their technological components) may differ radically. Said another way: Each physician in the same specialty is assumed to be using the same technological resources, regardless of what procedure he is performing or where he is performing it.

For example, the RVS payment (based on the Hsiao methodology) to a dermatologist for surgical removal of a port wine stain would assume the dermatologist uses the same level of technology as all other dermatologists in all other dermatology procedures. Yet to remove the port wine stain, a laser is used, and this will cost more than the average technology cost Hsiao assumes for each dermatology procedure. And even for those dermatologists who use lasers, there are different kinds of lasers. Bottom line: Some dermatologists will be overcompensated, others undercompensated.

That is the basic problem. But the basic problem may be aggravated by another aspect of the Hsiao methodology -- the way practice costs for a specialty are associated with procedures in that specialty.

As the Commission has noted, Professor Hsiao assigns a specialty's practice costs (including assumed costs of technology) to each procedure in the specialty at a rate that is proportional to the "total work" (a separate tributary of the RVS formula) required for that procedure. The assumption is that technology costs will be high where total work is high and low where total work is low.

Reality, however, may stubbornly resist such a neat pattern. Total work -- time, mental effort, technical skill -- may, in at least some instances, be inversely related to costs of technological resources. For example, an arthroscope can reduce a physician's total surgical time. Yet under the Hsiao methodology, a surgeon who invests in an arthroscope, and whose total work is thus lowered, will be incorrectly assumed to have realized a concomitant reduction in technology costs.

Dr. Hsiao has acknowledged that technology-intensive procedures are undervalued. He suggests addressing this problem through the "conversion factor," the multiplier that would convert RVS weights to dollars. This~~,~~ however, would raise the system's accounting for technological resources to a more global (and less precise) level.

Our recommendation goes the other way. We prefer the Commission's service-specific methodology, which more closely ties a physician's technological resources to the individual procedures in which those resources are used. Again, we reserve final judgem~~ent~~ until we can more thoroughly analyze the Commission's work.

II. RVS Maintenance Issues: Allowing Physicians to Get the Tools They Need

An RVS system must not only be constructed well. It must keep working well over time. We are pleased that the Commission recognizes the importance of this.

Health care, like most things, is not static. Nor should it be. Does anyone want to go back to the care we had a decade ago? To that of five years ago? And what about what we have today? Freezing the current level of technology is no more attractive than using iron lungs to fight polio.

An RVS must capture health care's changes in a timely, effective, and fair way. If this is not done, and done systematically, the dynamism of medicine will collide with the rigidity of regulation, producing requests for an RVS overhaul.

It is to us instructive that the Prospective Payment Assessment Commission (ProPAC), now five years into its experience with DRG's, has recognized the importance of a payment system flexible enough to keep pace with changing medicine:

- With about 2 1/2 years of DRG experience available to it, ProPAC, in 1986, said this:

  > [A] recalibration schedule should be set in advance so that the hospital industry can anticipate when changes in the weights will occur... Given how quickly practice pattern changes that affect relative resource use among the DRGs can occur, the four-year maximum cycle is clearly too long to keep the weights current. Even with an annual cycle, the most current patient billing data will be two years older than the year for which the weights are set.

- Also in 1986, ProPAC recommended annual recalibration of the DRG weights, finding these adjustments "necessary to account for changes in medical practice, technology and... coding." (The law was amended to make this change.)

Keeping an RVS system current is in at least some ways more challenging than keeping DRG's current.

The data on which DRG system changes are based are hospital charges and/or costs. This is information hospitals routinely compile. And it is information HCFA routinely collects on an annual basis. Thus, as charge and/or cost data is received by HCFA and recorded, it can be used to make changes in the DRG weights and classifications.

The data source for a resource-based RVS, however, is not so readily available, since the key, underlying factors are physicians' total work and practice costs. Unlike hospital charges and/or costs, data on physicians' total work and practice costs is not routinely or easily collected. It can be acquired only through complex and painstaking surveys (witness the extent of Professor Hsiao's own total work).

These difficulties, however, make an up-to-date RVS no less important. While the Commission has begun to address this issue, we suggest the Subcommittee and the Commission explore the following specific approaches:

A. An interim, more immediate adjustment mechanism

We urge the Subcommittee to explore ways for an RVS to recognize new technologies on an interim, more immediate basis.

This is particularly important for RVS, since, as noted above, data on physicians' total work and practice costs must be acquired through time-consuming surveys. This means the data may be collected less frequently than is optimal, thus delaying recognition of new technologies unless an interim mechanism is in place.

Such a mechanism could allow new things to be coded and paid for temporarily until more complete, survey-based judgments could be made. During such an interim period, physicians and others could submit information that would allow the later judgments to be more informed.

What's the alternative? If past is prologue, the alternative is to wait -- and to wait a long time -- for a decision to be made. A recent report by an HHS advisory committee, for example, found that new technologies queue up an average 2.4 years for a national Medicare coverage decision.

If unacceptable for an established regime like Medicare coverage, delays of this kind are inexcusable for a system we now have the power to shape. RVS is such a system. It should be shaped to avoid delay and to facilitate integration of changing medical practice. An interim mechanism may be one way to accomplish this.

B. Mechanisms for updating the system

In addition to an interim mechanism, the RVS system should be periodically updated. Among the mechanisms the Subcommittee should consider are an update to the conversion factor each year and a survey of physicians' total work and practice costs as frequently as is feasible.

C. Accurate and Credible Criteria

The interim adjustment and updating mechanisms should be grounded in clear criteria that measure -- accurately, objectively, predictably -- the resource and practice changes taking place in medicine. This is not an area that abides imprecision. For imprecision can breed caprice, and that can cause confidence in the system to fail.

The Subcommittee's goal should be to make RVS revisions -- like the system being revised -- as fair, effective, and predictable as possible.

III. Conclusion

We close as we began by saying that this RVS system, to be a better system, must be well constructed and carefully maintained. We stand ready to work with the Subcommittee on these and other important RVS issues.

STATEMENT OF MARTHA McSTEEN, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. The National Committee represents over five million members and supporters, most of whom are senior citizens. Physician payment reform is not only a pocketbook issue for the Medicare program and doctors, but it is also a pocketbook issue for senior citizens. They now spend 18 percent of income for out-of-pocket health care costs.

While the Harvard researchers and the Physician Payment Review Commission have done valuable work, it is up to Congress to see that these recommendations translate into more affordable and accessible health care for older Americans.

> **The National Committee has outlined beneficiary criteria for physician payment reform which include financial protection, quality care, and information and assistance (see attached). We would hope that physician payment reform would provide Congress the opportunity to address all these issues, but at a minimum it should guarantee beneficiaries financial protection from doctor charges above what Medicare allows and from Part B premium increases.**

As we said in our statement last year, an overwhelming 72 percent of respondents to a National Committee member survey agreed that the federal government should regulate doctor and hospital fees. Two-thirds of the membership ranked, as one of their top two Medicare priorities, that doctors be required to accept assignment. Controlling premium increases was also a high priority.

We are dissappointed that the Physician Payment Review Commission did not recommend limiting doctor charges to what Medicare allows.

Past reports of the Commission have noted that the burden of doctor overcharges exceeds $3.1 billion a year in additional out-of-pocket costs for beneficiaries. Beneficiaries frequently don't know whether or not their doctors will overcharge them or, if so, by how much. Patients who are seriously ill face the largest bills and have the least choice about doctors. The new Medicare Catastrophic Coverage Act will provide little help for these expenses, which are usually not covered by private medigap insurance.

While considerably less than the last year's Part B premium increase of 38.5 percent, this year's premium increase of 12.5 percent (before the increase for catastrophic care) was more than triple the cost-of-living adjustment (COLA) for Social Security benefits. If the premium for catastrophic care is included, the premium increase is 28.6 percent. In other words, the premium has increased almost thirty percent in each of the last two years.

Beneficiaries have some reason to hope that next year's basic premium increase (excluding catastrophic) will be no more than four percent because current law would limit the premium increase to no more than the COLA. Unfortunately, the Administration has proposed increasing Part B premiums to cover 25 percent of program costs which would cost beneficiaries $10.5 billion dollars over five years, or approximately $300 per beneficiary.

Congress has an opportunity to reform Medicare payments for doctors in a way that will assure that beneficiaries are financially protected, that doctors are paid equitably and that patients are assured access to high-quality medical care.

Thank you.

Beneficiary Criteria for Physician Payment Reform

FINANCIAL PROTECTION

Eliminate "balance billing." Without a limit on doctor charges above what Medicare allows, the imposition of any fee schedule will do little more than serve as an open invitation to doctors to "balance bill" beneficiaries to compensate themselves for lost income. This is a particular danger with regard to specialty surgeons; their record on accepting assignment has been the worst, and now, under any conceivable fee schedule imposed by Congress, they stand to lose the most.

Limit Part B premium increases. Increases in Part B premiums should be tied to increases in the Social Security cost-of-living adjustment (COLA), as provided under current law for 1990 and future years. Medicare beneficiaries pay $382.80 per year in part B premiums alone. This is the out-of-pocket cost for a healthy Senior who does not visit a doctor even once for an entire year. The Administration proposes to increase Part B premiums to cover 25 percent of program costs. This could cost beneficiaries up to $10.5 billion over five years.

QUALITY CARE

Assure that care is necessary and appropriate. Since 1972, Medicare has relied on utilization review to identify unnecessary or inappropriate care. It has not worked well, and the Physician Payment Review Commission concluded that, as currently practiced by Medicare, it can't—"without risk of reducing quality of care." The commission favors a clearer focus, more research and less secrecy.

Assure that care meets quality standards. The only leverage that Medicare has is to deny payment to doctors who provide substandard medical care. In 1986 Congress ordered Medicare to actually start doing this. Implementing regulations only recently have been proposed. They would provide for the denial of payment only when medical care results in "actual, significant, adverse effect."

The peer review organizations (PROs) whose job is to watchdog doctors have failed to do so, according to the Physician Payment Review Commission. Its 1988 report cited a HCFA finding that half the PROs "failed" their contractor performance evaluations because they had done nothing about the instances of inept or harmful medical care they had discovered.

INFORMATION AND ASSISTANCE

Make program rules clear and understandable. Abolish needlessly complex rules (e.g., the MAAC) that are incomprehensible and annoying to patients and doctors alike. Agency and carrier communications to beneficiaries should be clear and understandable, timely and polite.

Assist beneficiaries in filing claims and appeals. Restore Medicare's practice of offering help to beneficiaries in local Social Security offices. Encourage Medicare carriers to undertake efforts in "beneficiary outreach," as suggested by the Physician Payment Review Commission.

Publicize clinical criteria and physician performance data. Throughout its 1988 report to Congress, the Physician Payment Review Commission called upon beneficiaries to help reduce the volume and intensity of medical services and to help eliminate services of marginal value. The Commission acknowledged the obvious fact that doctors are the key decision-makers. Neverthless, it wants beneficiaries, their families and organizations to help control doctors' prices and doctors' behavior. This is not remotely possible unless beneficiaries and advocates have the data and information on which to base informed decisions.